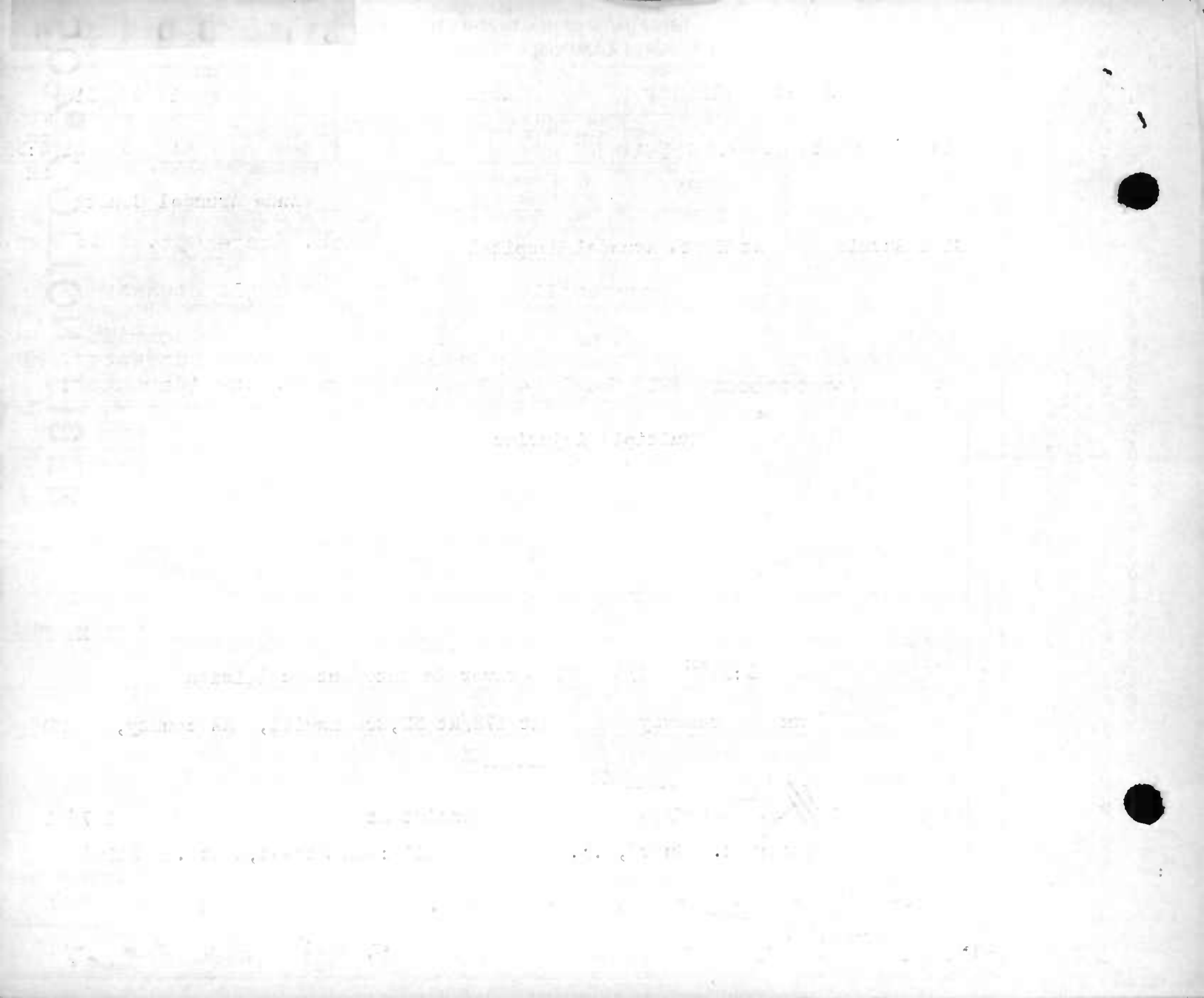


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 00104 | | | | | |
|--|--|-------------|-------------|--|--|---|--|--|------------|-------------------|--|---|--|--|--|-----------------------------------|--|
| FOR 1- STATE REGISTRAR | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST James | | | MIDDLE Henry | | | LAST Abend | | | 20. DATE KNOWN OF DEATH | | 2b. HOUR | | | |
| | | | | | | | | | | | | ESTIMATED <input checked="" type="checkbox"/> 1 6 19 81 | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | | |
| male | | white | | Sept. 15, 1910 | | 70 YRS. | | MONTHS | | DAYS | | 1 6 19 81 | | 4:35 pm | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MD | | | | USA | | | | | | | | Anne Arundel County MD | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Glen Burnie | | | | At North Arundel Hospital | | | | | | | | Ret. Store Opt. | | | | self emp. | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| MD | | AA | | Crownsville | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Generals Highway | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| FIRST Adolph | | | | | | MIDDLE Abend | | | | | | FIRST Louise | | MIDDLE Schmidt | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | | | |
| NO | | | | XXXXXXXXXXXX | | | | 216/14/3994 | | | | Mrs. Barbara M. Day (daughter) Edgewater, MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Multiple injuries | | | | | | | | | | | | | | | | | |
| 8120 | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | | | | | 3:30 PM 1/6 1981 | | | | | | driver in auto/auto collision | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f. LOCATION | | | | | |
| | | | | | | roadway | | | | | | Rt 178/Rt 32, Crownsvill, AA county, MD | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural Causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | TITLE (SPECIFY) | | | | | | DATE SIGNED | | | | | |
| Hormez R. Guard, M.D. | | | | | | Assistant | | | | | | 1/7/81 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | ADDRESS | | | | | | | | | | | |
| Hormez R. Guard, M.D. | | | | | | 111 Penn Street, Balto. MD 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | | | |
| Burial | | | | 10 Jan 81 | | Glen Haven Mem. PK | | | | Glen Burnie AA MD | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| SINGLETON FUNERAL HOME, GLEN BURNIE, MD | | | | | | | | | | | | JAN 8 1981 | | [Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 0 1 0 5

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|--|--|---|--|--|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Betty G Abendschein | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-24-81 | | | 2b. HOUR 3:40 M | | | | | |
| 3 SEX F | | 4 RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 11-21-25 | | 6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Albamarle N.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD. | | | | | |
| 10 CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY ----- | | | |
| 13a. STATE Md. | | | 13b. COUNTY A.A. Co. | | 13c. CITY OR TOWN Edgewater | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1704 Quantico Rd. | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Irving Gudger | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dealie Byrd | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO. 245-22-1648 | | | 17 INFORMANT ADDRESS Chester B. Abendschien same as 13e. | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma to bone, spine, brain 1509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) Esophageal carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) ----- APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE John J. ... | | | | | | DEGREE | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/26/81 | | 23c. NAME OF CEMETERY OR CREMATORY Friendship Methodist | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Friendship Md. | | | |
| 24 FUNERAL DIRECTOR NAME Hardesty Funeral Home 12 Ridgely Ave. Ann. Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 26 1981 | | | 25b. REGISTRAR'S SIGNATURE John J. ... | | |

[Handwritten signature]

JAN 2 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | EST | |
|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Othella (nmi) ADAMS | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 21, 1981 | | 2b. HOUR 9:14 PM | |
| 3 SEX female | | 4 RACE white | | 5 DATE OF BIRTH MONTH DAY YEAR Feb. 29, 1912 | | 6 AGE (IN YEARS LAST BIRTHDAY) 68 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10 CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY Clothing Mfg. | |
| 13a. STATE MD | | 13b. COUNTY AA | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Pearl North | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (UNKNOWN) | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO XXXXXXX | | 17 INFORMANT Mrs. Lorraine Phillips (daughter) | | 18. ADDRESS same as 13 | | | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u> 4275 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Carcinoma of colon with Metastasis</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Basant K. Khandelwal</u> | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/22/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BASANT K. KHANDELWAL, M.D. | | 22e. ADDRESS 205 Baltimore Annapolis Blvd. Glen Burnie, Md. 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 24 Jan 81 | | 23c. NAME OF CEMETERY OR CREMATORY Security Process Inc | | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balt. MD | |
| 24 FUNERAL DIRECTOR NAME J. Easter | | ADDRESS Singleton Funeral Home, Glen Burnie, MD | | 25a. DATE REC'D. BY REGISTRAR JAN 21 1981 | | 25b. REGISTRAR'S SIGNATURE <u>Robert McQuinn</u> | |

BP

000000

100-101424

10/1/19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8100107

REG. NO.

E.S.T.

| | | | | | |
|--|---|---|---|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME FIRST MIDDLE LAST WILLIAM L. ADAMS | | JANUARY 28, 1981 | | 5:30A M | |
| 3. SEX MALE | 4. RACE Negro | 5. DATE OF BIRTH MONTH DAY YEAR 3 12 09 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Conts. |
| 13a. STATE Md | | 13b. COUNTY AA Co | 13c. CITY OR TOWN Glen Burnie | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Enoch Adams | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosie Toyer | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | |
| 16b. SOCIAL SECURITY NO. 214-30-3425 | | 17. INFORMANT Nellie Tolman Bessick | | ADDRESS 229 Bolton Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> 4280 DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-24</u> 19 <u>81</u> , to <u>1-28</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>1-28</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Sang C. Doh, M.D. | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-28-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANG C. DOH, M.D. | | 22e. ADDRESS 95 AQUAHART ROAD GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (BY) | | 23b. DATE 1-31-81 | | 23c. NAME OF CEMETERY OR CREMATORY ST Rest | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Hanover AA Md | | 24. FUNERAL DIRECTOR Thurmon B Oden - Balto. Md | | | |
| 25a. DATE REC'D. BY REGISTRAR FEB 2 1981 | | 25b. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

29

8 1 0 0

P.S.T.

JANUARY 29, 1981 2:30A

ADTS

CHITIN



WINE ARDOL, OXLEY

KEITH WILSON, HOSPITAL

GLEN BURKE

GLEN BURKE, WYLAND 21031
05 AUMINAT ROAD

8000 C. DOL, N.D.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8100108

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN THIRKELD Aisquith | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 10 81 | | | 2b. HOUR AM | |
| 3. SEX M | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 7 13 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AA GEN. Hospt. | | | | 12a. USUAL OCCUPATION (TYPE OR WORK FOR LOSS OF WORKING LIFE) FARMER FARMING | |
| 13a. STATE MD. | | 13b. COUNTY AA | | 13c. CITY OR TOWN AA | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN HENRY Aisquith | | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMMA BURGESS | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO. 218-12-9208 | | 17. INFORMANT ADDRESS Ruth Higgs Aisquith #13 | | | | | |

| | | | | | |
|--|--|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden death. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4140 } DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) History of myocardial infarction (c) Chronic atherosclerotic heart disease | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Cardiovascular disease & history of CVA | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/21/80 to 1/10/81 , that (I) (we) lost saw the deceased alive on 7/21/80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE George C. Samaras | | | | 22c. DATE SIGNED 1/12/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE C. SAMARAS | | | | 22e. ADDRESS 1616 Faust Drive Annapolis | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 1/2/81 | | DAVIDSONVILLE PATH | |
| 23d. LOCATION (CITY OR TOWN) COUNTY | | 23e. DATE FILED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | |
| DAVIDSONVILLE AA MD. | | JAN 1 1981 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

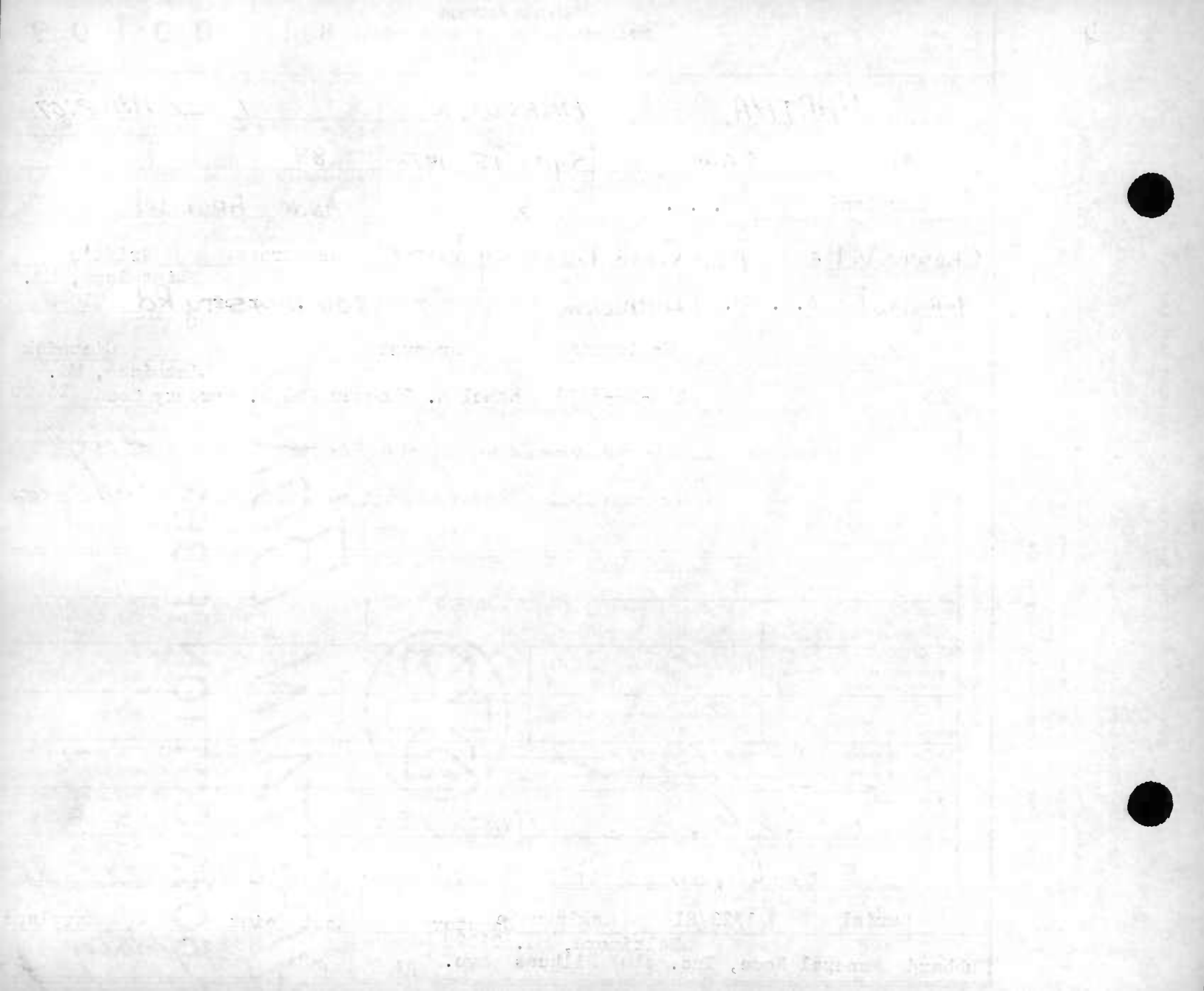
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8100109

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | | |
|--|--|--|---|---|---------------------------------------|---|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTHA BALDWIN | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 20, 1981 | | 2b. HOUR 8:07 AM | | | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 9 15 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH CROWNSVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairfield Nursing Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY Grift's | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY A.A. Co. | | 13c. CITY OR TOWN Linthicum | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 806 W. Nursery Road | | 13f. ADDRESS Linthicum, Md. 21090 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Andrew Wawizyniak | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Ciezniak | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 218-36-6576 | | | 17. INFORMANT ADDRESS Ethel E. Glaeser 806 W. Nursery Road 21090 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 4960 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Lung Disease DUE TO, OR AS A CONSEQUENCE OF (c) Unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROPRIATE INTERVAL BETWEEN DEATH AND AUTOPSY Brief | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from 1/20 19 81 , to 1/20 19 81 , that (we) lost saw the deceased alive on 1/20 19 81 , and that in (my) last opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) not view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE R. I. Hochman, MD | | | | | | 22c. DATE SIGNED 1/20/81 | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. I. Hochman, MD | | | |
| 22e. ADDRESS 16 Murray Ave, Annapolis, Md 21403 | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/23/81 | | | 23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE East Point Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR 21229 | | | 25b. REGISTRAR SIGNATURE Jan 23 1981 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81

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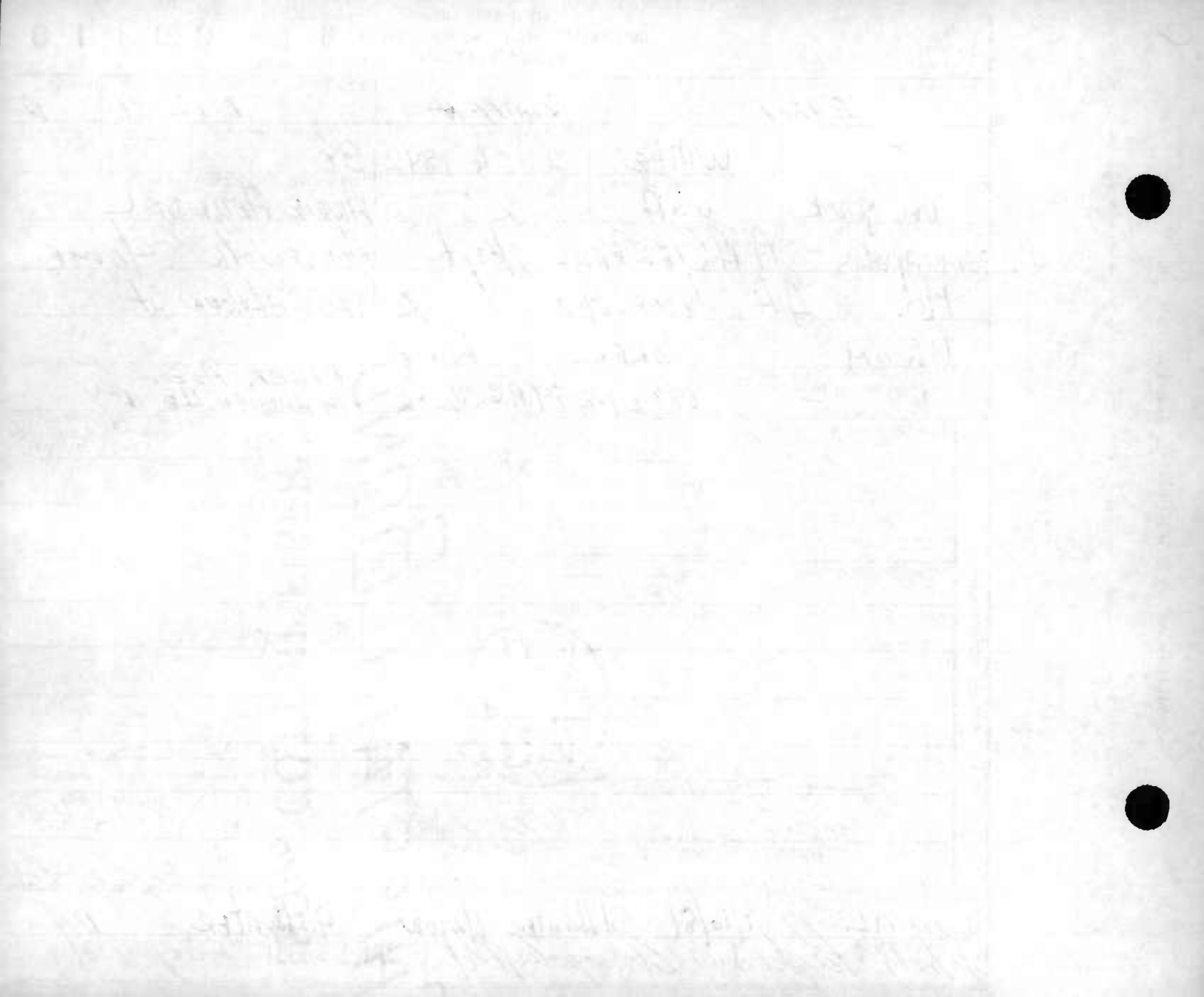
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1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ethel Bartlett | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 12 81 | | | 2b. HOUR AM | | | |
| 3. SEX F | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 2 24 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 | | 7. IF UNDER 1 YEAR MONTHS DAYS 88 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION A. H. GENERAL Hospt. | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) MD. AA Edgewater | | 13b. CITY OR TOWN Edgewater | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS 125 CALHOUN ST. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Bloom Baker | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Loea | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) NO | | | | | |
| 16b. SOCIAL SECURITY NO. 083-09-7059 | | 17. INFORMANT R.G. CHANCE | | 17a. ADDRESS 319 PARK AVE. MECHANICVILLE N.Y. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancerous of the Colon 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7-8 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/24, 1980 to 1/12, 1981 , that (I) last saw the deceased alive on 1/11, 1981 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) (we) did did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE R. I. Hochman | | DEGREE MD | | 22c. DATE SIGNED 1/12/81 | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. I. Hochman, MD | |
| 22e. ADDRESS 16 Murray Ave, Annapolis, Md | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | | | | |
| 23b. DATE 1/16/81 | | 23c. NAME OF CEMETERY OR CREMATORY Stillwater Union | | 23d. LOCATION CITY OR TOWN COUNTY STATE Stillwater U.Y | | 24. FUNERAL DIRECTOR John M. Layton Sons Annapolis, Md. | | | |
| 25a. DATE REGD. BY REGISTRAR JAN 14 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Item 5, 8 G 553 3/12/81 GB | | | | STATE OF MARYLAND | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 81 00111 | |
|--|--|--|--|---|--|--|--|---|--|
| 1 - STATE REGISTRAR | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| WALTER W. BEALL | | | | | | 1-11-81 | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | |
| Male | | White | | January 26, 1921 | | 59 62 | | 5:38 M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Anne Arundel County MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Annapolis | | Anne Arundel County Hospital | | | | Foreman | | Chemical Co. | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Maryland | | | | Anne Arundel | | Arnold | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 13e. STREET ADDRESS | | | |
| Walter W. Beall | | | | Sarah Owens | | 815 MacSherry Drive | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | | | None | | Myrtle Beall 5805 42nd Ave. #217 Hyattsville, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>LUNG CANCER</u> | | | | | | | | WEEKS | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>3-15</u> , 19 <u>80</u> , to <u>1-11</u> , 19 <u>81</u> , that (1) <input checked="" type="checkbox"/> we last saw the deceased alive on <u>1-11</u> , 19 <u>81</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) <input checked="" type="checkbox"/> (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | |
| <u>Ronald Piccetti</u> | | | | MD | | | | 1-12-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| RONALD PICCETTI | | | | Anne Arundel County Hospital Annapolis, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | Jan/15/81 | | Ft. Lincoln Cemetery | | Brentwood, P.G. Co., Maryland | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | 25a. RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | |
| Chambers Funeral Home | | | | Riverdale, Maryland | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8100112 | |
|--|--|--|--|--|--|--|--|--|---|---------|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | | | | EDT | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | |
| JULIA ELIZABETH BEATTY | | | JANUARY 14, 1981 | | | 8:10A M | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | |
| Female | | | White | | | May 12 1894 | | | 86 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Romania | | | U.S.A. | | | | | | ANNE ARUNDEL COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| GLEN BURNIE | | | NORTH ARUNDEL HOSPITAL | | | Cook | | | Restaurant | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | |
| Md. | | | A.A. | | | Linthicum | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13e. STREET ADDRESS | | | | | |
| Lawrence Beatty | | | unknown | | | 820 Oregon Ave. | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| no | | | 218 09 3832 | | | Catherine Quinlan | | | Arnold, Md. 21012 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | IMMEDIATE CAUSE (a) | | | DUE TO, OR AS A CONSEQUENCE OF | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 4960 | | | Respiratory failure | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | (b) | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | Metabolic acidosis | | |
| | | | | | | (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-4, 1981, to 1-14, 1981, that (I) (we) lost saw the deceased alive on 1-13, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | |
| SACIT EREN, M.D. | | | 529 S. CAMP MEADE ROAD LINTHICUM, MARYLAND 21090 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | | 1/17/81 | | | Cedar Hill Cemetery | | | Brooklyn Md. | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. SIGNATURE | | |
| George J. Gonce | | | 4001 Ritchie Hgwy. Balto Md. | | | JAN 16 1981 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 0 1 1 3 E.S.T. | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ANDREW JOSEPH BLAHUT | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 13, 1981 | | | |
| 3. SEX Male | | | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR April 20, 1893 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Czechoslovakia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | | 2b. HOUR 5:20 A.M. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Coast Guard | | | | 12b. KIND OF BUSINESS OR INDUSTRY Boilermaker | | | |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Valentina Blahut | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-05-5649 | | 17. INFORMANT ADDRESS Mrs. Sophie Soustek 7513 Solley Road 21061 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 1 wk | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Auto MZ; Acute recurrent CHF; V-Tach. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/13/81 to 1/13/81 , 19 81 , that (I) (we) last saw the deceased alive on 1/13/81 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE DAVID A. SCHWARTZ, D.O. | | | | 22c. DATE SIGNED 1/13/81 | | 22d. ADDRESS 7845 OAKWOOD ROAD, SUITE 200 GLEN BURNIE, MARYLAND 21061 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/17/81 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie Anne Arundel Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Mc Cully Funeral Home of Brooklyn 237 E. Patapsco Avenue Baltimore, Md. 21225 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

BP

| RECEIVED | | DATE | | TIME | | PLACE | |
|----------|-----|------|-----|------|-----|-------|-----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 |
| 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 |
| 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 |
| 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 |
| 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 |
| 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 |
| 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 |
| 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 |
| 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 |
| 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 |
| 97 | 98 | 99 | 100 | 101 | 102 | 103 | 104 |
| 105 | 106 | 107 | 108 | 109 | 110 | 111 | 112 |
| 113 | 114 | 115 | 116 | 117 | 118 | 119 | 120 |
| 121 | 122 | 123 | 124 | 125 | 126 | 127 | 128 |
| 129 | 130 | 131 | 132 | 133 | 134 | 135 | 136 |
| 137 | 138 | 139 | 140 | 141 | 142 | 143 | 144 |
| 145 | 146 | 147 | 148 | 149 | 150 | 151 | 152 |
| 153 | 154 | 155 | 156 | 157 | 158 | 159 | 160 |
| 161 | 162 | 163 | 164 | 165 | 166 | 167 | 168 |
| 169 | 170 | 171 | 172 | 173 | 174 | 175 | 176 |
| 177 | 178 | 179 | 180 | 181 | 182 | 183 | 184 |
| 185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 |
| 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-clippers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 1 0 0 1 1 4
EST

REG. NO.

| | | | | | |
|--|--|---|--|---|---|
| DECEASED NAME (TYPE OR PRINT) PAUL FRANCIS BOLYARD SR. | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 15, 1981 | | 2b. HOUR 5:28A M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR May 23, 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self employed | | 12b. KIND OF BUSINESS OR INDUSTRY Carpenter |
| 13a. STATE Md. | | 13b. COUNTY Anne Arundel | 13c. CITY OR TOWN Pasadena | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Bolyard | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Chloie Rosien | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 222-16-9563 | | 17. INFORMANT ADDRESS Norma L. Bolyard same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory arrest 4/00 DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Basant K. Khandelwal | | DEGREE M.D. | | 22c. DATE SIGNED 1/15/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BASANT K. KHADELWAL, M.D. | | 22e. ADDRESS 205 BALTIMORE ANNAPOLIS BOULEVARD GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/19/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven em. Park | |
| 24. FUNERAL DIRECTOR NAME Mc Cully F. H. Mountain & Tick Neck Rds. | | ADDRESS Pasadena, Md. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, Anne Arundel Md. | |
| | | 25a. DATE REC'D. BY REGISTRAR JAN 21 1981 | | | |

RECEIVED
JAN 11 1981



DATE: JAN 11 1981
FACILITY: KENNELS
PATIENT: KENNELS
STREET: KENNELS

ONE ANIMAL ONLY

CLINICAL RECORD

CLINICAL RECORD

CLINICAL RECORD

CLINICAL RECORD

100% COTTON



305 BATTLES IN ARCADES
CLINICAL RECORD

CLINICAL RECORD

JAN 11 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8100115 |
|---|--|--|---|---|--|---|-----------------------|--|--|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | EST | | | |
| 1. DECEASED NAME (TYPE OR PRINT) WALTER K. BORNE | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 4, 1981 | | | | 2b. HOUR 9:50 P.M. | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 4/27/20 | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY SECURITY | | |
| 13a. STATE MD. | | 13b. COUNTY AA | | 13c. CITY OR TOWN BALTO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 406 PAMELA RD | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ALBERT BORNE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT MARY BORNE | | ADDRESS ABOVE | | | | |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Septic Shock</u> | | | | | | | | | | 18 Lys |
| 1579 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Purulent Small bowel perit.</u> | | | | | | | | | | 7 days |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Ca Pancreas</u> | | | | | | | | | | 3 months |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION 12/28/80 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Generalized Peritonitis | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/27</u> , 19 <u>80</u> , to <u>1/4</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>1/3</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/5/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CTRADUSIL | | | | 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE JAN. 6, 81 | | 23c. NAME OF CEMETERY OR CREMATORY SECURITY PROCESS | | 23d. LOCATION CITY OR TOWN COUNTY STATE CATONSVILLE MD. | | | | |
| 24. FUNERAL DIRECTOR NAME CONNELLY FUNERAL HOME | | | | ADDRESS 300 MACE AVE | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1981 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 0 0 1 6 | |
|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | EDT | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| BRANTLY E. BOTELER | | | | JANUARY 9, 1981 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | |
| Male | | Caucasian | | May 4, 1914 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | |
| Maryland | | USA | | 66 | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| | | | | ANNE ARUNDEL COUNTY MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Retired | | AA County | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Md. | | AA | | Glen Burnie | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Joseph B. Boteler | | Lessie Mae Dorney | | 13e. STREET ADDRESS | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Yes WW 2 | | | | Melvin Boteler, same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Squamous cell carcinoma of the lung</i> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| CHARLES J. WU, M.D. | | 7845 OAKWOOD ROAD, #204 GLEN BURNIE, MARYLAND 21061 | | 1-9-81 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | Jan. 12, 81 | | Glen Haven Mem. Pk. | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE OF DEATH | |
| James S. Kirkley, Glen Burnie, Md. | | | | JAN 13 1981 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | |

Name: Joseph
 Address: 1000
 City: New York
 State: New York
 Zip: 10000
 Date: 1/1/51

(Faint, illegible text in the middle section of the document)

JAN 1 1951
 (Faint, illegible text at the bottom of the document)

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARY B. BRADY | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 21 81 | | | 2b. HOUR 4:55 PM | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 6 15 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 69 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hairdresser | | 12b. KIND OF BUSINESS OR INDUSTRY Beauty | |
| 13a. STATE Md. | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Annapolis | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Morton Burris | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Fowler | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | |
| 16b. SOCIAL SECURITY NO. 214-05-0352 | | 17. INFORMANT James E. Brady | | ADDRESS 207 Giddings Ave. Annapolis, Md. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxic Brain Damage 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Acute, Superior Myocardial Infarction Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 15 Jan 81 to 21 Jan 81 , that (I) (we) lost saw the deceased alive on 15 Jan 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Don B. Lowe | | | | DEGREE Attending Physician | | 22c. DATE SIGNED 21 Jan 81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Don B. Lowe | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/24/81 | | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Md. | |
| 24. FUNERAL DIRECTOR NAME John Taylor & Sons | | | | ADDRESS Annapolis, MD | | 25a. DATE REC'D. BY REGISTRAR JAN 23 1981 | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

35
53
35
221
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

11100



[Faint, illegible handwriting on lined paper]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

Jan. 15, 1981

12:30 PM

| | | | | | | | | | | | |
|--|--|--|---|---|----------------------------------|--|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Liona Esterline Brammer | | | 2a. DATE OF DEATH MONTH DAY YEAR Jan. 15, 1981 | | | 2b. HOUR 12:30 PM | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 3, 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE COUNTRY Lerona, W. Va | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH AACo MD | | | | | |
| 10. CITY OR TOWN OF DEATH Crownsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1477 Fairfield Loop Rd. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Md | | | 13b. COUNTY AACo | | 13c. CITY OR TOWN Crownsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1477 Fairfield Loop Rd. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ballardc | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cleopatra Phillips | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | | | 16b. SOCIAL SECURITY NO. 212 54 9808 | |
| 17. INFORMANT ADDRESS / Ocien Lilly, Crownsville, Md | | | | | | | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Heart failure

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

immediate

4289
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Presbycardia

DUE TO, OR AS A CONSEQUENCE OF

(c) -----

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

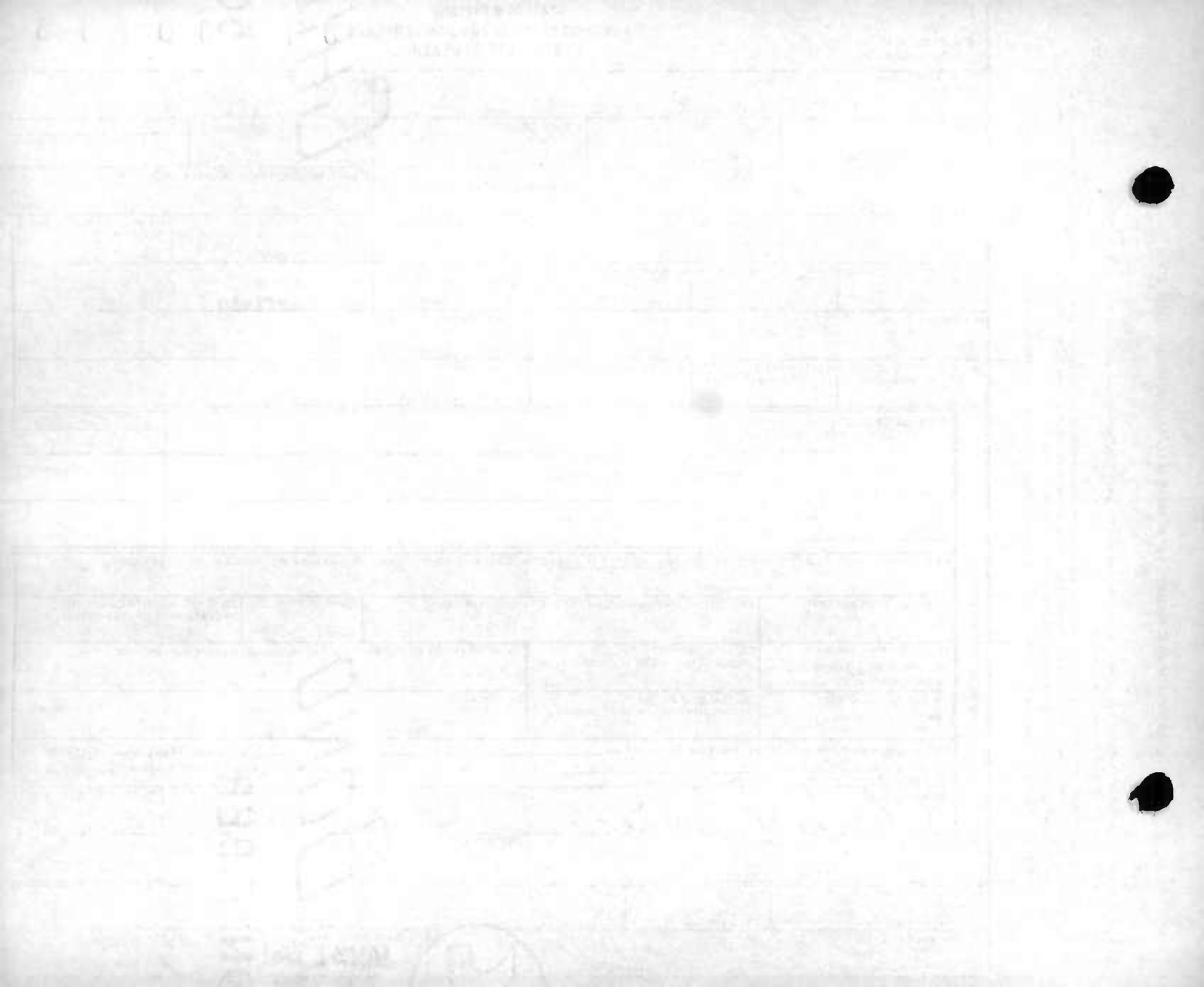
| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION n/a | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 22, 1976, to Jan 15, 1981, that (I) (we) lost saw the deceased alive on Jan 14, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Charles W. Kinzer | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED Jan. 15, 1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles W. Kinzer MD | | | | 22e. ADDRESS Annapolis, Md | | | |

| | | | | | | | |
|---|--|----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-17-81 | | 23c. NAME OF CEMETERY OR CREMATORY Phillips Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Lerona, W. Va, Mercer Co | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Hardesty FH, 12 Ridgely Ave, Annapolis, Md. 21401 | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 21 1981 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Ann R. Brandt | | | 2a. DATE OF DEATH MONTH DAY YEAR January 3, 1981 | | | 2b. HOUR M 11 | | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR February 16, 1924 | | 6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD | | | |
| 10 CITY OR TOWN OF DEATH Severna Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 542 Devonshire Court | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Severna Park | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 542 Devonshire Court 21146 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harry Rouse | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Raisin | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-58-9925 | | 17. INFORMANT ADDRESS Walter C. Brandt, Same as #13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of the pancreas 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 mo | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 10, 1967 to January 3, 1981 , that (I) (we) last saw the deceased alive on January 3, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE R. M. McLaughlin, M.D. | | | | DEGREE M.D. | | | | 22c. DATE SIGNED 1/3/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. M. McLaughlin, M.D. | | | | 22e. ADDRESS 3708 Mountain Rd. Pasadena, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-6-81 | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | | | ADDRESS 1050 York Rd. | | 25a. DATE REC'D. BY REGISTRAR JAN 7 1981 | | 25b. REGISTRAR'S SIGNATURE R. M. McLaughlin | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 00120
E.S.T.

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) HARRIET Josephine BROCATO | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 8, 1981 | | | 2b. HOUR 5:04 A.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 2, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY own home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 6 "D" Street N.W. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST BERT A. DULL | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE R. MONN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT (Husband) Mr. Samuel D. Brocato | | ADDRESS Same as # | | # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>day</u> <u>years</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Pneumonia & sepsis</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-7-81</u> to <u>1-8-81</u> , that (I) (we) last saw the deceased alive on <u>1-7-81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Jack I. Stern</u> DEGREE | | | | | | 22c. DATE SIGNED <u>1-8-81</u> | | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) JACK I. STERN, M.D. | | | | | | 22f. ADDRESS 300 HOSPITAL DRIVE, SUITE 135 GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10 JAN. 81 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. PK. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A. MD. | | | |
| 24. FUNERAL DIRECTOR NAME SINGLETON Funeral Home | | 24b. ADDRESS Glen Burnie, Maryland | | 25a. DATE REC'D. BY REGISTRAR JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE <u>Robert H. Kennedy</u> | | | |

0-100-18



RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 OF YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

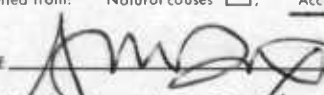
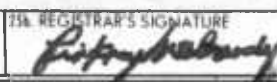
DHM-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00121

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | |
|--|--|-------------------------|--|--|--|---|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) EDWARD BROWN | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 11 19 81 | | | 2b. HOUR M 2:23 | | | | | | | | | |
| 3. SEX male | | 4. RACE negro | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 20 1935 | | 6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 11 19 81 | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County | | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MARYLAND | | | 13b. COUNTY A.A. | | | 13c. CITY OR TOWN ANNAPOLIS | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 1905 F. Copeland Street | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM BROWN | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE RUBY PARKER | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 213-32-9734 | | | 17. INFORMANT ADDRESS LILLIAN BROWN 1905 F. Copeland St. Annapolis, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Closed head injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Seizure disorder | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9:30 1-11- 1981 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject apparently fell. | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1300 blk. Forest Dr., Annapolis, Anne Arundel, Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED 1-12-81 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | | | 23b. DATE 1-17-1981 | | | | 23c. NAME OF CEMETERY OR CREMATORY PINELAWN MEM. PARK | | | | 23d. LOCATION Annapolis A.A. Maryland | | | |
| 24. FUNERAL DIRECTOR WILLIAM REESE & SONS MORTUARY, P.A. | | | | | | | | 25. DATE REC'D. BY REGISTRAR JAN 14 1981 | | | | 26. REGISTRAR'S SIGNATURE  | | | |

6026 (OLD) ON 41013

LEFT IN HAND



[Handwritten signature or scribble]

JAN 1 1941

[Handwritten signature or scribble]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGE 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00122

| | | | | | |
|---|--|---|---|--------------------------------------|---|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2c. DATE ESTIMATED | | 2d. HOUR | |
| FIRST MIDDLE LAST | | MONTH DAY YEAR | | MONTH DAY YEAR | |
| DONALD | | BULLOCK | | 1981 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. |
| Male | White | 2 4 02 | 78 YRS | MONTHS DAYS HOURS MIN | MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED | NEVER MARRIED | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Illinois | USA | WIDOWED | DIVORCED | ANNE ARUNDEL | MD. |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 9th BERNIE | NORTH BRUNDEL Hospital | SHOP MAINT. | RAILROAD | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Ind. | | SHERERVILLE | YES | BURGUNDY ST. | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST | FIRST MIDDLE LAST | | | | |
| Unknown | Unknown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (son) | ADDRESS SEVERNA Pk. Md. | | |
| No | 489 106329 | G.H. Bullock | 361 MARBA RD | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Hypertensive Cardiovascular disease | | | | | |
| 4029 DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | |
| (b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION | | |
| | | | STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| E. Linhardt | | M.D. Deputy | | 1-1-81 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| E. Linhardt | | Annapolis, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
| Burial | 1/4/81 | MT VERNON MEN. CDS | MT VERNON | JEFFERSON | 911. |
| 24. FUNERAL DIRECTOR (NAME) | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE | |
| Robert S. Banawan | Severna Pk Md. | | JAN 5 1981 | Robert S. Banawan | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 0 0 1 2 3 | |
|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | EST | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| MARY T. BURTON | | JANUARY 21, 1981 | | 11:20 A | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| Female | White | 3-24-1890 | 90 YRS. | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Ind. | U.S.A. | | ANNE ARUNDEL COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| GLEN BURNIE | NORTH ARUNDEL HOSPITAL | | Housewife | | at home |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| Ind. | G.A. Co. | Glen Burnie | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1812 Lemming Rd. 21061 |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| Joseph Caroline | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| No | | 213-18-7148 D | Mary Galloway - 3804 Tharrel Ave. 21430 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cardiac failure shock | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) MI with new CBBIS | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Ischemic bowel syndrome - 1 day | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/21/81, 1981, to 1/21/81, 1981, that (I) (we) last saw the deceased alive on 1/21/81, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Recep Erol | | MD | | 1/21/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| RECEP EROL, M.D. | | B25 HOSPITAL DR., GLEN BURNIE, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | |
| Burial | | 1-24-1981 | Eden Hill Cem. | CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| John J. Brown, Jr., Inc. 901 N. Hollins St. | | JAN 25 1981 | | | |

0 8 0

OS:121 1501 15 JANUARY 1951

BURTON

T.

WATZ

THIRD ARCADE COUNTY

WATZ ARCADE HOSPITAL

WATZ ARCADE HOSPITAL

14-11

14-11

14-11

CHARTERED BY THE BOARD OF DIRECTORS

WATZ ARCADE HOSPITAL

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN TO THE DIVISION OF VITAL RECORDS WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M7/77

| FOR LILLIAN (nmn) DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|
| 1- STATE REGISTRAR CAMMARATA MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 81 00124 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <u>Lillian (nmn) Cammarata</u> | | | | | | 2b. DATE KNOWN OF DEATH ESTI. MATED <u>81 7 1981</u> | | 2c. HOUR <u>1 A M</u> | |
| 2. SEX <u>Female</u> | | 4. RACE <u>White</u> | | 3. DATE OF BIRTH <u>AUG. 25 21</u> | | 5. AGE IN YEARS <u>59</u> | | 6. IF UNDER 1 YR. MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN. <u>0</u> | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Anne Arundel Co.</u> MD | | | |
| 10. CITY OR TOWN OF DEATH <u>Glen Burnie</u> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>North Arundel Hospital</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOUSEWIFE</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | |
| 13a. STATE <u>MARYLAND</u> | | | | | | 13b. COUNTY <u>A.A.</u> | | 13c. CITY OR TOWN <u>PASADENA</u> | |
| 14. FATHER'S NAME FIRST <u>Bernard</u> MIDDLE <u>Bartasavich</u> LAST <u>Melvina</u> | | | | | | 15. MOTHER'S MAIDEN NAME FIRST <u>HEADAVICH</u> MIDDLE <u>HEADAVICH</u> LAST <u>HEADAVICH</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>no</u> | | 16b. SOCIAL SECURITY NO. <u>216.12.9291</u> | | 17. INFORMANT (Son) <u>Mr. Bruce Cammarata</u> | | ADDRESS <u>Same as #13</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4029</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) <u>Due to, or as a consequence of</u> (c) <u>Due to, or as a consequence of</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <u>E. Linhardt</u> | | | | TITLE (SPECIFY) <u>Deputy</u> MEDICAL EXAMINER | | | | DATE SIGNED <u>1-8-81</u> | |
| EXAMINER'S NAME (TYPE OR PRINT) <u>E. Linhardt</u> | | | | ADDRESS <u>Annapolis, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>10 JAN. 81</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Pk.</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Glen Burnie A.A. Md.</u> | | | |
| 24. FUNERAL DIRECTOR NAME <u>J. Easter</u> ADDRESS <u>Glen Burnie, Maryland</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 12 1981</u> | | 25b. SIGNATURE <u>[Signature]</u> | | | |

[Faint, illegible handwriting and markings throughout the page, including a circular stamp on the right side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 0 1 2 5 | | | |
|--|--|---|--|---|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Helen C Camden</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>1/22/81</i> | | 2b. HOUR <i>5:40 AM</i> | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>09 25 13</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <i>67</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Idaho</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Annapolis</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel Gen. Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired Pilot</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Flying</i> | |
| 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>A.A.</i> | | 13c. CITY OR TOWN <i>Annapolis</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Frederick L. Cavis</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Fern Reid</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>*****</i> | | 17. INFORMANT ADDRESS <i>Mary Cavis, 127 Bayview Dr., Maryland</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cat cell carcinoma</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1979</i> , 19____, to <i>1/22/81</i> , 19____, that (I) (we) last saw the deceased alive on <i>1/21/81</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE DEGREE <i>Stanley P. Watkins</i> MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>1/22/81</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Stanley P. Watkins</i> | | | | 22e. ADDRESS <i>121 Cathedral Ave., Annapolis, Md.</i> | | | |
| 23a. BURIAL, CREMATION, OR REINTERMENT (SPECIFY) <i>Cremation</i> | | 23b. DATE <i>1/22/1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Metropolitan Crematory</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Alexandria, Virginia</i> | |
| 24. FUNERAL DIRECTOR NAME <i>Beall Funeral Home</i> | | | | 25a. DATE REC'D BY REGISTRAR <i>JAN 26 1981</i> | | 25b. REGISTRAR'S SIGNATURE <i>Robert McCready</i> | |
| 1212 West St., Annapolis, Maryland | | | | | | | |

BP



Idaho U.S.A. Anne Arundel
Annapolis Anne Arundel Gen. Hospital Retired Pilot Flying
Maryland A.A. Annapolis x 127 W. 8 view Drive
Frederick L. Davis Fern
no ----- Mary C vis, 127 B view Dr., M. Tylon
Annapolis
R. E.

x

1212 West St., Annapolis, Maryland
Real Funeral Home
xxxxxx 1/22/1981 Metropolitan Cemetery Alexandria, Virginia
Cremation
Stanley P. W. tkins
121 Cathedral Ave., Annapolis, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8100126 | |
|--|--|---|--|---|--|--|--|---|---|---------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES H. CARROLL | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 17 81 | | | 2b. HOUR 740A.M. | | | |
| 3. SEX MALE | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 1 19 24 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN ANNAPOLIS | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 940 Madison St. Apt. A 3 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CHARLES H. CARROLL | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE ANDERSON | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 218-16-3114 | | 17. INFORMANT ADDRESS KATIE STEWART 940 Madison St. Apt. A 3 Annapolis, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5860 CARDIOPULMONARY arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Renal Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINS DAYS WEEKS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from 1-16-81 to 1-17-81, that (b) (we) lost saw the deceased alive on 1-17-81, and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Ronald Pickett M.D. | | | | DEGREE M.D. | | | | 22c. DATE SIGNED 1/18/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RONALD PICKETT | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE 1-21-1981 | | 23c. NAME OF CEMETERY OR CREMATORY PINELAWN MEM. PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 26 1981 | | 25b. REGISTRAR'S SIGNATURE R. H. Brady | | | | | |

MEDICAL CERTIFICATION

422

STATION 1

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M. chrysops

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5. Summary & Conclusions

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

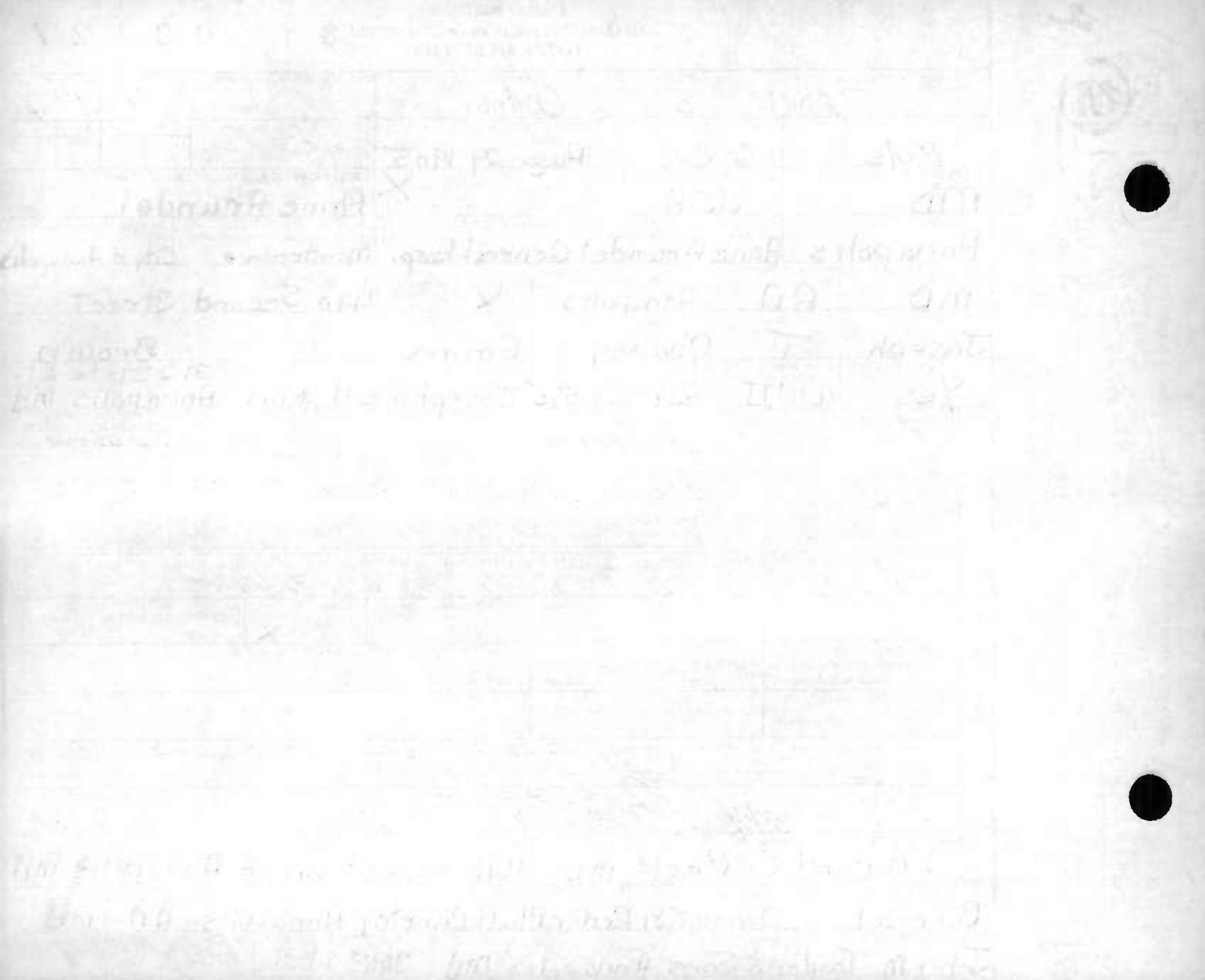
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8100127 | | | | | | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|--|--|---|--|--|---|--|-----------------------------|--|-----------------------------|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 8 81 | | | | | | | 2b. HOUR 11:30 AM | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Daniel B Chaney | | | | | 3 SEX male | | | | | 4 RACE COC | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 29, 1905 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) MD | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp. | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) maintenance | | | | | 12b. KIND OF BUSINESS OR INDUSTRY City of Annapolis | | | | | | | | | |
| 13a. STATE MD | | | | | 13b. COUNTY AA | | | | | 13c. CITY OR TOWN Annapolis | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET ADDRESS 410 Second Street | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph T. Chaney | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Brown | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | | 16b. SOCIAL SECURITY NO. 1-8-81 | | | | | 17. INFORMANT ADDRESS Josephine Hopkins 312 State St. Annapolis, Md. | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4049 DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC VASCULAR RENAL DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 5 DAYS 2 YRS. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CHRONIC OBSTRUCTIVE PULMONARY DIS; GI BLEEDING | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-8-81 12:27, 19 81, to 1-8-81, that (I) (we) lost (specify) above, (I) (we) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Edward S. Beck | | | | | | | | | | 22c. DATE SIGNED 1-8-81 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward S. Beck MD | | | | | | | | | | 22e. ADDRESS 1616 Forest Drive, Annapolis, MD | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | 23b. DATE Jan. 10, 1981 | | | | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME John M. Taylor & Sons, Annapolis, Md. | | | | | | | | | | 25a. DATE REC'D BY REGISTRAR JAN 13 1981 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8100128 EST | | | |
|---|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) JUNE B. CHERRY | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 6, 1981 | | | |
| 3. SEX Female | | | | 2b. HOUR 8:34 P.M. | | | |
| 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 6 17 87 | | 6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Anne Arundel | | | |
| 13c. CITY OR TOWN Glen Burnie | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 13e. STREET ADDRESS 7501 Woodhaven Co. | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Vincent Bellamy | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Armecia Taylor | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS Vivian Vaughn 7501 Woodhaven Court | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> 3453 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Status epilepticus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic obstructive pulmonary disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from <u>3 Jan</u> 19 <u>81</u> , to <u>6 Jan</u> 19 <u>81</u> , that (1) (we) last saw the deceased alive on <u>6 Jan</u> 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Lorraine M. Dailey</u> | | | | DEGREE MD | | 22c. DATE SIGNED 1-6-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LORRAINE M. DAILEY, M.D. | | | | 22e. ADDRESS 8667 Fort Smallwood Rd. Pasadena, Md. 21122 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/10/81 | | 23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville MD. | |
| 24. FUNERAL DIRECTOR NAME WILLIAM C. MARCH FUNERAL HOME INC. | | | | ADDRESS 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1981 | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 0 1 2 9

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|---|---|--|-------------------------------------|---|---|-----------------------------------|-----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| FIRST MIDDLE LAST Stuart M. Christhilf Jr. | | | MONTH DAY YEAR 1-26-81 | | | 7:15 P M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS (LAST BIRTHDAY)) | | | 7. IF UNDER 1 YEAR | | |
| MALE | White | MONTH DAY YEAR Aug. 18, 1916 | 64 YRS. | | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | USA | | | | ANNE ARUNDEL CO MD | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Annapolis | ANNE ARUNDEL GENERAL HOP | | | Physician | | | Gynecologist | |
| 13a. STATE | | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | |
| MD | | | AA | Beverna PK. | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 3 Riverview Road | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST Stuart M. Christhilf | | | FIRST MIDDLE LAST Eloise MacNeal | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| Yes | | | WW II | | | Marion F. Christhilf Same as #13a | | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> | | Days | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral infarct</u> | | Days | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ventricular fibrillation</u> | | Days | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Ischemic heart disease, diabetes mellitus

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>1/26/81</u> , 19 <u>81</u> , to <u>1/26/81</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>1/26/81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE <u>General Church</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>1/27/81</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GERARD CHURCH</u> | | 22e. ADDRESS <u>86 ravenswood, Severna Park, Md 21146</u> | | | | | |

| | | | |
|--|----------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u> | 23b. DATE <u>Jan 28, 1981</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u> | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Brentwood P.G. MD</u> |
| 24. FUNERAL DIRECTOR NAME <u>John M. Taylor & Sons - Annapolis, MD</u> | | 25a. DATE RECEIVED BY REGISTRAR <u>FEB 5 1981</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77
(VR A 15 (4))

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|---|---|--|---|---|
| 1. FOR STATE REGISTRAR | | 8 1 0 0 1 3 0 | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) IRENE CLAPSADDE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-6-81 | | | 2b. HOUR 12:50 P.M. | |
| 3. SEX FEMALE | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 4 6 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH CROWNSVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FAIRFIELD NURSING CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD. | | 13b. CITY OR TOWN P.A. | | 13c. CITY OR TOWN CROWNSVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS RT. 3-Box 524- | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John G. Emmert | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie Boulter | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 173-03-0567B | | 17. INFORMANT ADDRESS 331 S. Riverside Dr. Victor E. Clapsaddle Crownsville, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4409 DUE TO, OR AS A CONSEQUENCE OF (b) a.s.v.d. with emphysema DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1-6-1981 to 1-6-1981 , that (I) (we) lost saw the deceased alive on 1-6-1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Emily H. Wilson | | 22c. DATE SIGNED 1-6-81 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Emily H. Wilson | | | | | |
| 22e. ADDRESS 4837 Solomons Island Rd., Edgewater, Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/9/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Waynesboro Pa. | | | |
| 24. FUNERAL DIRECTOR NAME Edward H. Gave | | ADDRESS 50 S. Broad St. | | DATE JAN 12 1981 | | | | | |

MEDICAL CERTIFICATION

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1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 0 1 3 1

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Dora E Clark | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 / 13 / 81 | | 2b. HOUR 9 25 PM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 11 / 22 / 83 | | 6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD | |
| 10. CITY OR TOWN OF DEATH Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY HOME | |
| 13a. STATE MD | | 13b. COUNTY AA | 13c. CITY OR TOWN Annapolis | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 1306 Cohow Dr. |
| 14. FATHER'S NAME FIRST MIDDLE LAST HENRY KUMMER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOHANNAH ESCHELMAN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. - | | 17. INFORMANT ADDRESS MRS KENNETH JARBOE #13 | |

MEDICAL CERTIFICATION

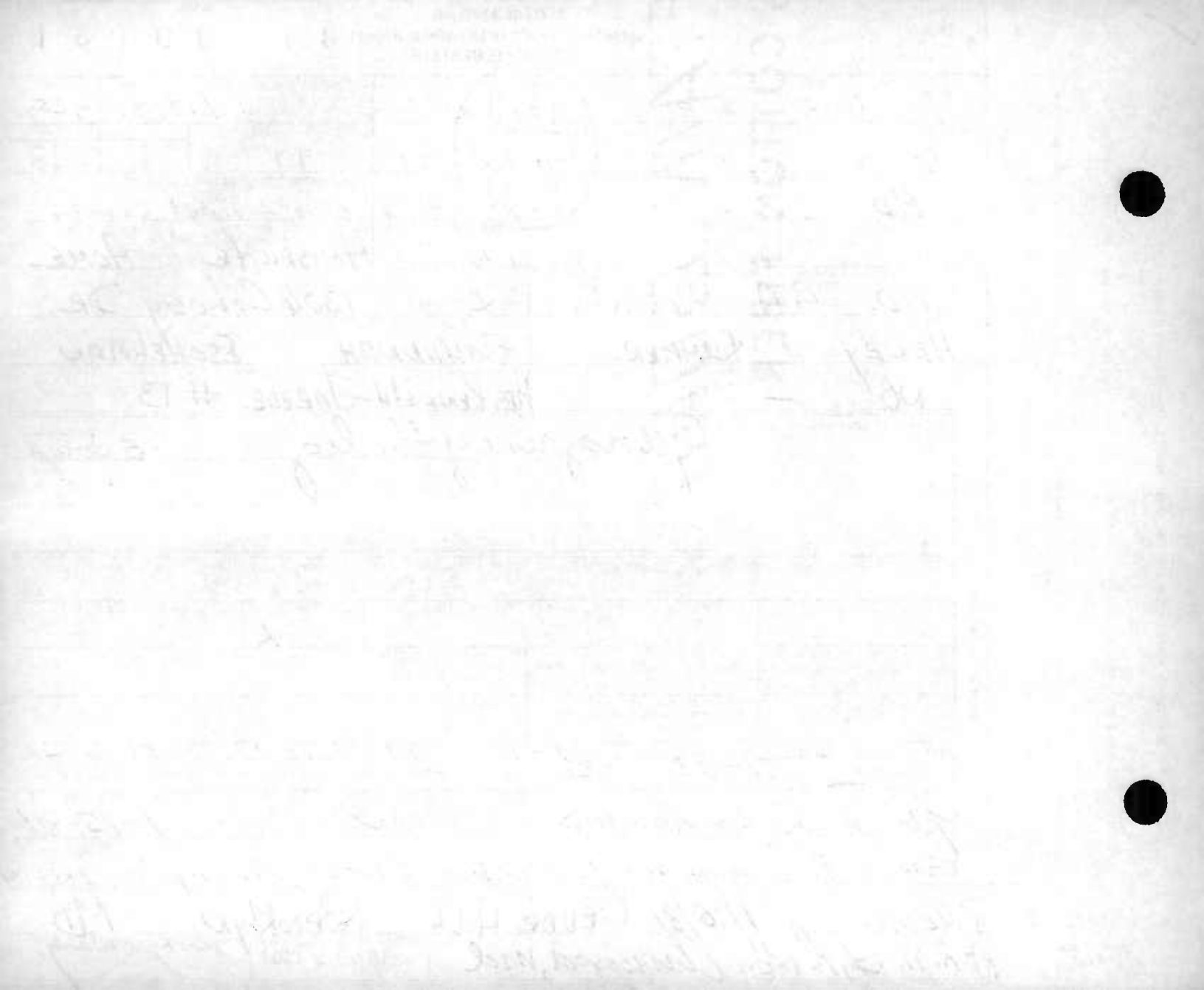
| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene of the leg DUE TO, OR AS A CONSEQUENCE OF (b) 7854 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-11 , 19 81 , to 1-13 , 19 81 , that (I) (we) lost saw the deceased alive on 1-13 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | |

| | | |
|--|---|------------------------------------|
| 22b. SIGNATURE Gary M. Richardson, MD | DEGREE | 22c. DATE SIGNED 1-15-81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY M. RICHARDSON, M.D. | 22e. ADDRESS 104 Forbes Street, Annapolis, MD 21401 | |

| | | | |
|---|-----------------------------|---|--|
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 1/16/81 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | 23d. LOCATION (CITY OR TOWN) COUNTY STATE Brooklyn MD |
| 24. FUNERAL DIRECTOR NAME ADDRESS John M. Lyle, Son Funeral Home, Inc. | | 25a. DATE REC'D. BY REGISTRAR JAN 19 1981 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 1 | 0 | 0 | 1 | 3 | 2 | |
|---|--|--|---|--|--------|---|---------|--|---|---|---|-----------------|-------|-----------------|----------|----------|--|
| FOR 1- STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | MIDDLE | | LAST | | | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | |
| HUGO | | | | | | | COELIUS | | | JAN. | | | 30 | 1981 | 10:35 AM | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| MALE | | | CAUS. | | | 12 28 1911 | | | 69 | | | MONTHS | | DAYS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| DETROIT MICH. | | | USA | | | | | | A.A.Co. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| Annapolis | | | DCA. AA Gen Hosp. | | | Inspector | | | A.A. County | | | | | | | | |
| 13a. STATE | | | 13b. CITY OR TOWN | | | 13c. INSIDE CITY LIMITS? | | | 13d. STREET ADDRESS | | | | | | | | |
| Md | | | A.A | | | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | Round Bay P.O. Box 14 | | | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | |
| Unknown | | | Unknown | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | | | | |
| NO | | | | | | Jane Coelius - Above | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| IMMEDIATE CAUSE (a) Cordiac Arrest | | | | | | | | | | | | | | | | | |
| 4059 | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (b) Hypertensive Cardiovascular | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) Myocard | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| | | | P.M. 19 | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY | | STATE | | | |
| | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>N/A</u> , 19 <u>81</u> , to <u>N/A</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>N/A</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED | | | | | | | | |
| Jon B. Lowe | | | | | | | | | 31 Jan 81 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | | | | | | | |
| Jon B. Lowe | | | Annapolis, Md | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN | | | COUNTY | | STATE | | | |
| BURIAL | | | FEB. 2, 1981 | | | HILLCREST CEM. | | | ANNAPOLIS | | | A.A. | | md. | | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| BARRANCO | | | 501 Ritchie Hwy PARK MD. | | | FEB 4 1981 | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These permits remove carbon papers. Pages 1 and 2 should be filed with the death certificate. 5 State Dept. of Health and Mental Hygiene.

EMPOW. (Item 21 is marked item 18 shows an injury or other traumatic event, the medical examiner is required to be completed at the time of death. *Deputy Medical Examiner*

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8100133 | |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| CERTIFICATE OF DEATH | | | | | | | | | | EST | |
| 1. DECEASED NAME (TYPE OR PRINT) JAMES Marshall COLE, Sr. | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 27, 1981 | | 2b. HOUR 6:55P M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 6, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Press Rm. For. | | 12b. KIND OF BUSINESS OR INDUSTRY Alco | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | | 13b. CITY OR TOWN Glen Burnie | | 13c. STREET ADDRESS 108 Sunset Drive | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Tillford W. Cole | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jeanette Thomlinson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE | | 17. INFORMANT (Wife) Mrs. Isabelle M. Cole | | ADDRESS Same as # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CVI</i> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Sepsis, Diabetes mellitus. As HD post Dx of 81 hyp.</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19 | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1.27.81</i> to <i>1.28.81</i> , that (I) (we) last saw the deceased alive on <i>1.27.81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>C. Dorkan</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <i>1.28.81</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CENAP S. DORKAN, M.D. | | | | 22e. ADDRESS 7845 Oakwood Road #204 Glen Burnie, Maryland 21061 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 30 JAN. 81 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mm Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Singleton Funeral Home Md. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 30 1981 | | 25b. REGISTRAR'S SIGNATURE <i>Deputy Medical Examiner</i> | | | | | |

[Faint, mostly illegible text and markings across the page, possibly bleed-through from the reverse side. Some words like "1900" and "1901" are visible.]

[Vertical handwritten text on the right margin, possibly a date or reference number.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cushion covers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is checked or item 11 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 0 1 3 4 | | | |
|---|--|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | REG. NO. | | | |
| COLTES LEE COURTNEY | | | | JANUARY 7, 1981 | | | | E.S.T. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE | | 7b. HOUR | | | |
| Male | | Caucasian | | Oct. 9, 1904 | | 76 | | 4:37A | | M | |
| 7a. BIRTHPLACE | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Virginia | | USA | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | ANNE ARUNDEL COUNTY | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | Cab Driver | | Taxi | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Md. | | AA | | Glen Burnie | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 2859 Crilly Road | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| William COURTNEY | | | | Mildred MORRIS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| No | | | | 218-10-4673 | | Anna Jenkins, sister | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary Arrest | | | | | | | | | | Acute. | |
| 8880 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| Intertrochanteric Fracture (R) Hip. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| 31 DEC 80 | | Fracture (R) Hip. | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | | | | | | |
| <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | HOUR A.M. MONTH DAY YEAR — P.M. 12 26 1980 | | Fall at home. | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | |
| WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | Home | | 415A. 7859 Crilly Rd | | Glen Burnie | | A/A- | | Md. | |
| 22a. I certify that (1) (this hospital) attended the deceased from 29 DEC 19 80 to 7 JAN 19 81, that (1) (we) lost saw the deceased alive on 7 JAN 19 81, and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| Edwin C. Fulton, M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 1/7/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| EDWIN C. FULTON, M.D. | | | | 7445-A FURNACE BRANCH ROAD GLEN BURNIE, MARYLAND 21061 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY STATE | |
| Burial | | 9 Jan. 81 | | Meadowridge Mem.Pk. | | Elkridge, | | Howard, | | Md. | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| James S. Kirkley, Glen Burnie, Md. | | | | JAN 9 1981 | | L. Kirkley | | | | | |



1219

122 8/15

1992

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M
(VRA 15, 4) 1/79

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 7. REG. NO. | | 8 1 0 0 1 3 5 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Marguerite CRICKENBERGER | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Ann Arundel | | 10. IF UNDER 24 HRS. HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Annapolis Convalescent & Nursing Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY Ann Arundel | | 13c. CITY OR TOWN Edgewater | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 166 Cardamon Drive | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert C. Carper | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Lee Campbell | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | | |
| 16b. SOCIAL SECURITY NO. 217-28-7476 | | 17. INFORMANT ADDRESS Mrs. Dean Rodgers, 166 Cardamon Drive Edgewater, Maryland 21037 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4860 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 21 1981 to 1/21 19 81 , that (I) (we) lost saw the deceased alive on 1/21 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Rodney L. Brimhall M.D. | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1-21-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Rodney L. Brimhall M.D. | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 24 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Frederick Md. | | | |
| 24. FUNERAL DIRECTOR Smith Fideley Keeney | | 24b. ADDRESS 106 E. Church St., Frederick, Md. 21701 | | 24c. REC'D. BY REGISTRAR JAN 26 1981 | | 24d. REGISTRAR'S SIGNATURE Rodney L. Brimhall | | | |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 0 1 3 6

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>BESSIE Virginia CROTTY</i> | | 2a. DATE OF DEATH MONTH DAY YEAR <i>1 28 81</i> | | 2b. HOUR M <i>2 P</i> | |
| 3. SEX <i>F</i> | | 4. RACE <i>W</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>8 19 94</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>WEST Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>86</i> | |
| 10. CITY OR TOWN OF DEATH <i>Glen Burnie</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>NORTH ARUNDEL Convalescent Cen.</i> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County</i> MD. | |
| 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>A. A.</i> | | 13c. CITY OR TOWN <i>Glen Burnie</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>William Riley Akers</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Susan Bishop</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i> | | 16b. SOCIAL SECURITY NO. <i>233-09-8295-D</i> | | 17. INFORMANT ADDRESS <i>Nursing Home Records</i> | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>uterine carcinoma with metastasis</i> <i>1790</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <i>12-15-80</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Charles J. Wu</i> | | DEGREE <i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>Jan. 28, 1981</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>CHARLES J. WU MD</i> | | 22e. ADDRESS <i>7845 oakwood rd. Glen Burnie, Md.</i> | | | | | |

| | | | | | | | |
|---|--|-------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>1/31/1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Monte Vista Park</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Bluefield, Mercer, W.Va.</i> | |
|---|--|-------------------------------|--|---|--|---|--|

| | | | | | | | |
|--|--|------------------------------------|--|--|--|---|--|
| 24. FUNERAL DIRECTOR NAME <i>Raymond C. Fink</i> | | ADDRESS <i>Glen Burnie, Md.</i> | | 25a. DATE REC'D. BY REGISTRAR <i>FEB 3 1981</i> | | 25b. REGISTRAR'S SIGNATURE <i>Henry A. Brady</i> | |
|--|--|------------------------------------|--|--|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Three hundred, twenty

Two hundred, twenty

One hundred, twenty

One hundred, twenty

One hundred, twenty

One hundred, twenty

One hundred, twenty

One hundred, twenty

One hundred, twenty

One hundred, twenty

One hundred, twenty

One hundred, twenty

One hundred, twenty

One hundred, twenty

One hundred, twenty

One hundred, twenty

One hundred, twenty

One hundred, twenty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 0 1 3 7

REG. NO.

1- FOR
STATE
REGISTRAR

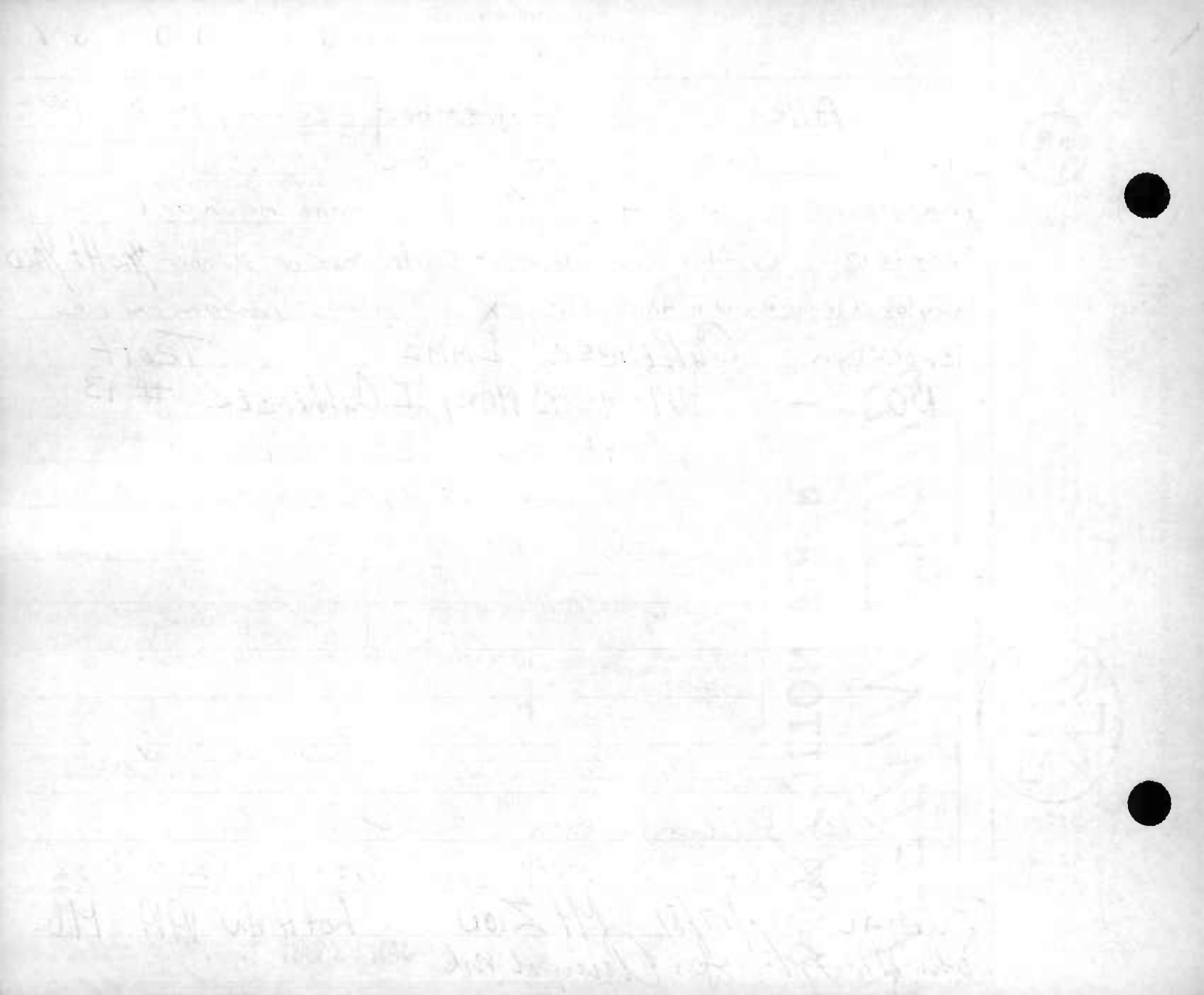
| | | | | | |
|--|--|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Allen Cullember | | | 2a. DATE OF DEATH MONTH DAY YEAR January 14 81 | | 2b. HOUR 1:50 P M |
| 3. SEX male | 4. RACE cau. | 5. DATE OF BIRTH MONTH DAY YEAR 10 12 02 | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | |
| 10. CITY OR TOWN OF DEATH Crofton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Crofton Convalescent Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) marine lumber | | 12b. KIND OF BUSINESS OR INDUSTRY YACHT YARD |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | 13c. CITY OR TOWN Annapolis | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 1205 marda lane |
| 14. FATHER'S NAME FIRST MIDDLE LAST Brooklyn CULLEMBER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA Teott | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 217-14-3942 | | 17. INFORMANT ADDRESS MARY I. CULLEMBER #13 | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia 3310 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pneumonia and pyelonephritis (c) Alzheimer disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

| | | | | | |
|--|--|---|--|---|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 12 , 19 81 , to Jan 14 , 19 81 , that (I) (we) lost saw the deceased alive on Jan 12 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) P R HODES MD | | 22c. ADDRESS 1662 Crofton Center Ctr | | 22e. DATE SIGNED | |

| | | | |
|---|--------------------------|--|---|
| 23a. BURIAL CREMATION REMOVAL (SPECIFY) Burial | 23b. DATE 1/17/81 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion | 23d. LOCATION CITY OR TOWN COUNTY STATE LOTHIAN AA MD. |
| 24. FUNERAL DIRECTOR NAME John M. Sykes ADDRESS Annapolis, Md | | 25a. DATE REC'D BY REGISTRAR JAN 19 1981 | 25b. REGISTRAR'S SIGNATURE |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | |
|--|------------------|---|--|---|--|---|--|---|--|---|--|---|--|--------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Julius | | MIDDLE Julius A. | | LAST Dahlke Dahlke | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 19 81 | | | | 2b. HOUR M 3:45 | | | |
| 3. SEX male | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR Sept 24, 1914 | | 6. AGE (IN YEARS) LAST BIRTHDAY 66 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 29 19 81 | | | | 2d. HOUR M 3:45 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Severn | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) wooden area Near R&R tracts | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | | | 12b. KIND OF BUSINESS OR INDUSTRY Army | | | | | |
| 13a. STATE Md. | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Severn | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1416 Grimm Road | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Dahlke | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Gerstung | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | (IF YES, GIVE WAR OR DATES) WWII | | 16b. SOCIAL SECURITY NO. 218-10-6053 | | 17. INFORMANT ADDRESS Mrs Hilda E. Schweinsberg Cecil Ave 5932 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) Chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE H.R. Swan | | | | TITLE (SPECIFY) Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED 1/30/81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. | | | | ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1/31/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME G. Truman Schwab | | | | ADDRESS 3512 Frederick Ave. | | | | 25a. DATE REC'D. BY REGISTRAR FEB 3 1981 | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 0 1 3 9

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY A DAHRINGER | | | 2a. DATE OF DEATH MONTH DAY YEAR January 20-1981 | | 2b. HOUR 3 P |
| 3. SEX Female | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR 2- 19- 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Conn. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH Crofton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Crofton Convalescent Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian-City of N.Y. | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. CITY OR TOWN Pr. Geo. Bowie | 13c. STREET ADDRESS 3008 Tanbark La. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Philip E. Hapenny | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ann Donnelly | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 121-03-0324 | | 17. INFORMANT ADDRESS Sara A. Winters Same as #13 | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Left ventricular failure 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months Years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/20 81 to 1/20 81 , that (I) (we) lost saw the deceased alive on 1/20 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Max C Frank MD | | DEGREE | | 22c. DATE SIGNED 1/20/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAX C FRANK MD | | 22e. ADDRESS 9755 Ritchie Hwy. Glen Burnie MD 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-23-81 | | 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart | |
| 23d. LOCATION CITY OR TOWN Bowie | | COUNTY Pr. Geo. Md. | | STATE | |
| 24. FUNERAL DIRECTOR Beall Funeral Home | | 25a. DATE REC'D. BY REGISTRAR JAN 26 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |
| 26. ADDRESS 16,000 Annapolis Rd. Bowie, Md. | | | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Female Caucasian 2-19-1888 22
Conn. U.S.A. x Anne Arundel
Crofton Crofton Convalescent Center Library-City of N.Y.
Mr. P.R. Geo. Bowie 3008 Tenth St.
Philip E. Henny Mary Ann Tonnelly
No 121-03-0324 Sara A. Winters Same as #13

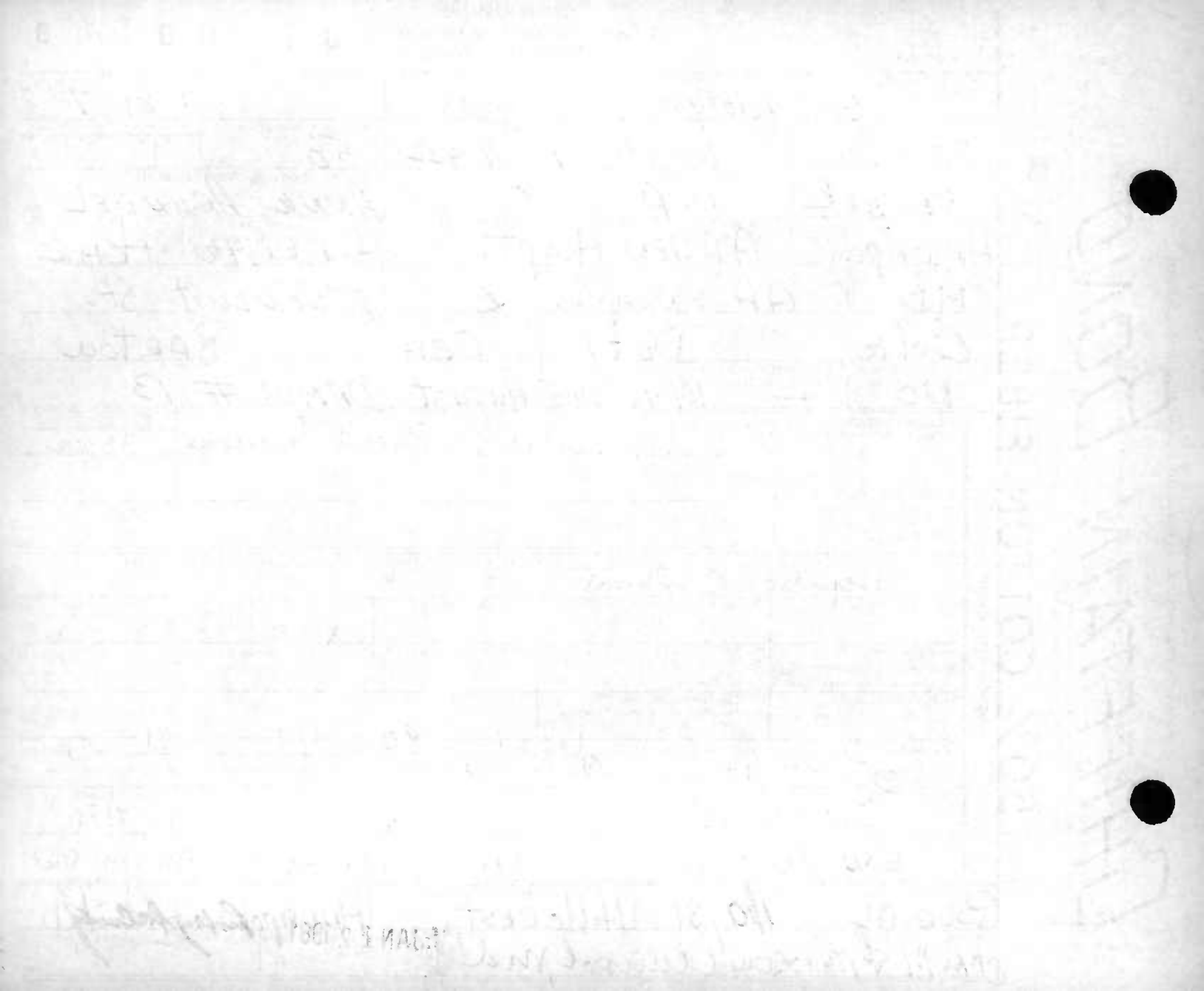
Burial 1-23-81 Secret Heart Bowie
8211 Funeral Home
16,000 Annapolis Rd. Bowie, Md.
P.R. Geo. M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 0 0 1 4 0 REG. NO. | | | |
|--|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gwendolyn Damps | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 7 81 | | | | 2b. HOUR 730A M | | | |
| 3. SEX Female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 1 11 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AA Hagen Hospt. | | | | 12. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORK OF LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY HOME | | | |
| 13a. STATE MD | | 13b. COUNTY AA Annapolis | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 75 Conduit St. | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Cohr Dotsy | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE ORA BARTON | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | |
| 16b. SOCIAL SECURITY NO. 101-16-2415 | | | | 17. INFORMANT August DAMPS # 13 | | | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1749 metastatic Breast Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year | | | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Hepatic Cirrhosis | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from 12/27/80 to 1/7/81, that (i) (we) lost saw the deceased alive on 1/6/81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (i) (we) (did) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE E.W. Cole III | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/7/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E.W. COLE III | | | | 22e. ADDRESS 121 CATHEDRAL ST ANNAPOLIS Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial | | 23b. DATE 1/6/81 | | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis Md. | | | |
| 24. FUNERAL DIRECTOR John M. Lyndon Annapolis, Md. | | | | 25. JAN 10 1981 | | | | 26. REGISTRAR'S SIGNATURE | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M/7/77
(VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 0 1 4 1

REG. NO.

| | | | | |
|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SUSAN E DEVLIN | | 2a. DATE OF DEATH MONTH DAY YEAR Jan 8 81 | | 2b. HOUR 0423 M |
| 3. SEX FEMALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR SEP 25 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. |
| 10. CITY OR TOWN OF DEATH FT MEADE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) US KIMBROUGH ARMY COMM HOSP | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | |
| 13a. STATE MARYLAND | | 13b. COUNTY PRINCE GEORGE | 13c. CITY OR TOWN LAUREL | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL PUSHKAR | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY KUNUSH | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 154-09-5429 | | 17. INFORMANT (SON) EUGENE J. DEVLIN ADDRESS 9580 MUIRKIRK ROAD APT 102 LAUREL, MD 20811 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5 JAN</u> 19 <u>81</u> to <u>8 JAN</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>8 JAN</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE * <u>Carlene Hawksley, Cpt, MC</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 8 JAN 1981 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARLENE HAWKSLEY | | 22e. ADDRESS KIMBROUGH ARMY COMM. HOSP, FGGM, MD 20755 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 1/12/81 | 23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE HOWARD MD. |
| 24. FUNERAL DIRECTOR FLOR LAUREL FUNERAL HOME, INC. 7601 SANDY SPRING RD. LAUREL, MD. 20810 | | 25a. DATE REC'D. BY REGISTRAR JAN 12 1981 | | |
| 25b. REGISTRAR'S SIGNATURE Barney McBrady | | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 6100142 EST | | | |
|--|--|--|--|--|--|--|---|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ROSALIE Townshend DOVE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 20, 1981 | | | | 2b. HOUR 11:10^A_M | | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH April 13, 1887^{AR} | | 6. AGE (IN YEARS LAST BIRTHDAY) 93 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balt. Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Sales Clerk | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE Md | | | | | 13b. COUNTY A.A. CO. | | 13c. CITY OR TOWN Pa sadena | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 248 Hickory Point Rd. | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) John C. Watson | | | | | 15. MOTHER'S MAIDEN NAME (MIDDLE LAST) Belle Coleman | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN no | | | | | 16b. SOCIAL SECURITY NO. 214-1000-10 | | 17. INFORMANT ADDRESS Rosalie V. Tager same as 13 a-e | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 6144 IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Septicemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Relieve Abscess | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from JAN 19 79 to JAN 20 81 , that (we) lost saw the deceased alive on 4/19 81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE MARC A. KAPLAN, M.D. | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/20/81 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARC A. KAPLAN, M.D. | | | | 22e. ADDRESS 7845 OAKWOOD RD., GLEN BURNIE, MARYLAND 21061 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1-23-81 | | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memo. Gardens | | 23d. LOCATION Annapolis, Md. COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR NAME Beall Funeral Home, 1212 West St., Annapolis, Md. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 26 1981 | | | | 25b. REGISTRAR'S SIGNATURE Rosalie V. Tager | | | | | |

24. FUNERAL DIRECTOR

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8100143 REG. NO. | | EST | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA Dragun | | | | JANUARY 6, 1981 | | 4:10 P.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 4 15 97 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Penna. | | | | 13b. COUNTY Phila. | | 13c. CITY OR TOWN Philadelphia | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Martin Andruszkiewicz | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Magdeline unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 166-05-6916 | | 17. INFORMANT ADDRESS Henry Dragun 857 Woods Rd. Pasadena 21122, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO Respiratory Result 4960 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anoxia + hypoxycapnea DUE TO, OR AS A CONSEQUENCE OF (c) COPD - CHF | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/6 19 81 , to 1/6 19 81 , that (I) (we) lost saw the deceased alive on 1/6 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Glenn F. Robbins | | | | DEGREE MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENN F. ROBBINS, M.D. | | | | 22e. ADDRESS 1404 Crain Highway, S., #300 Glen Burnie, Md. 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-10-81 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | | 23d. LOCATION CITY OR TOWN COUNTY STATE Philadelphia Pa. | |
| 24. FUNERAL DIRECTOR NAME George J. Gonce F. H. | | | | ADDRESS Balto. 21225 4001 Ritchie Hwy | | 25a. DATE REC'D. BY REGISTRAR JAN 12 1981 | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

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RECEIVED
JAN 10 1961



1961 JAN 10

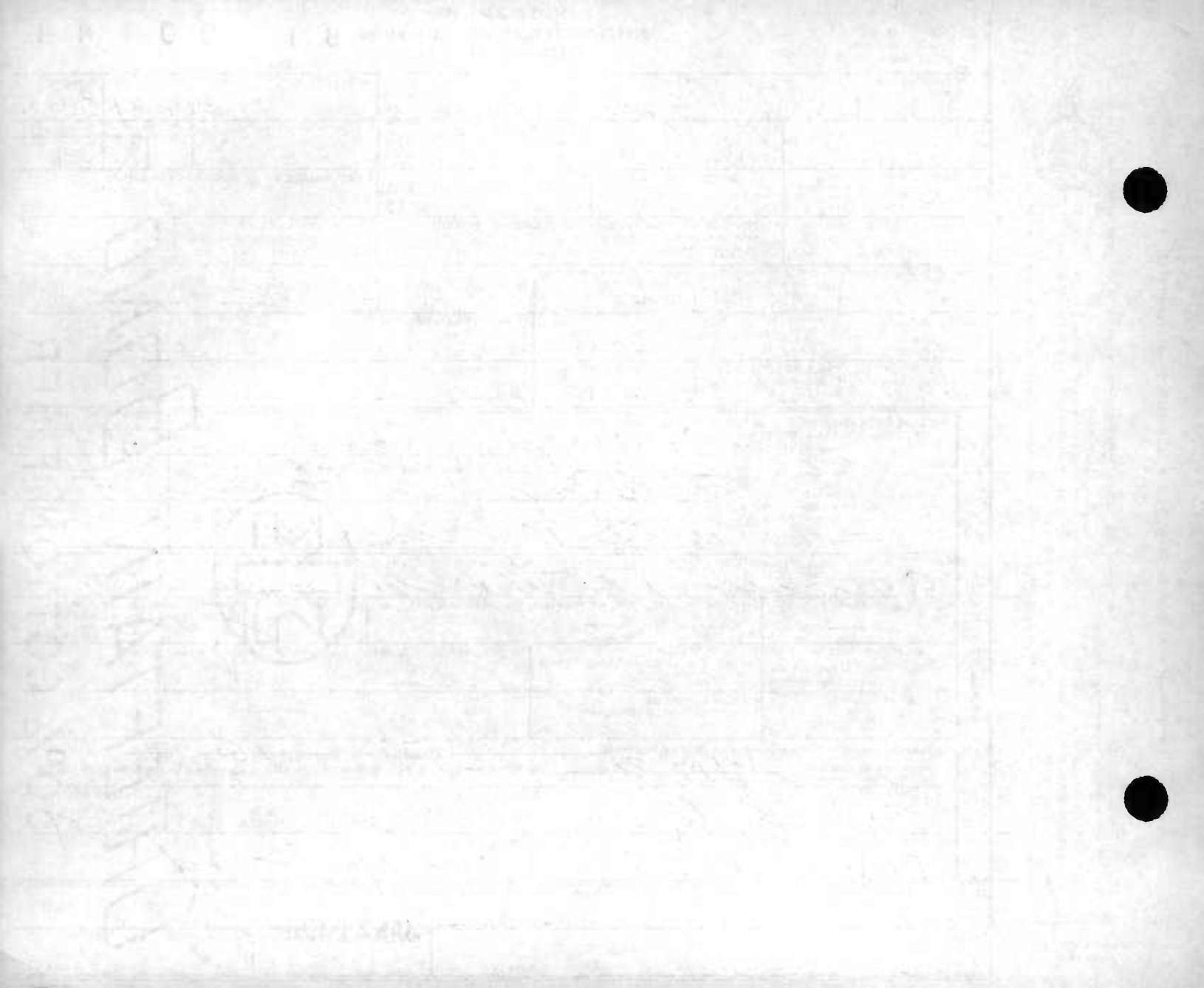
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 0 1 4 4 | |
|---|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edith Escott Ebaugh | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 16 81 | |
| 3 SEX Female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 04 17 98 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York City | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 10 CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AA General | | 9. BALTIMORE CITY OR COUNTY OF DEATH AA Co MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Editor | | | | 12b. KIND OF BUSINESS OR INDUSTRY State Dept. | |
| 13a. STATE Md | | | | 13b. COUNTY AA Co | |
| 13c. CITY OR TOWN Harwood | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 4703 Bayfield Rd. | |
| 14 FATHER'S NAME FIRST MIDDLE LAST William Escott | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Underhill | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 577 60 5192 | | 17. INFORMANT ADDRESS Shirley Heintz # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Myocardial Infarction</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 29 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Generalized atherosclerosis</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-16-81 to 1-16-81, that (I) (we) last saw the deceased alive on 1-16-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Frank Shipley | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-17-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) F.M. SHIPLEY | | 22e. ADDRESS Annapolis Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-21-81 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | |
| 23d. LOCATION CITY OR TOWN Arlington Va | | 23e. COUNTY STATE Va | | | |
| 24. FUNERAL DIRECTOR NAME Hardesty FH, 12 Ridgely Ave, Annapolis, Md 21401 | | 25. REGISTRAR'S SIGNATURE JAN 21 1981 REGISTRAR | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8100145 | |
|---|---|---|--|---|---|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) HARRY MILTON EDWARDS | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 04, 1981 | | 2b. HOUR 9:20A M |
| 3. SEX male | 4. RACE Negro | 5. DATE OF BIRTH MONTH DAY YEAR NOV 6 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saw Helper | | 12b. KIND OF BUSINESS OR INDUSTRY Exxon Chemical |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md 13b. COUNTY A.A. 13c. CITY OR TOWN FRANNSVILLE | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 982 Generals Highway - WATERBURY | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Edwards | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora MILNER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 218-16 3322 | | 17. INFORMANT ADDRESS Mary A. Jones Edwards - Same as 13E | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma of colon 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 80 to 1 4 19 81 , that (I) (we) lost saw the deceased alive on 1-4-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death. | | | | | |
| 22b. SIGNATURE <i>Duncan J. Ford</i> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-4-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANG C. DOH M.D. | | 22e. ADDRESS 95 AQUAHART RD GLEN BURNIE MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1-7-1981 | | 23c. NAME OF CEMETERY OR CREMATORY John Wesley | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE WATERBURY A.A. md | | 23e. DATE REC'D. BY REGISTRAR JAN 19 1981 | | | |
| 24. FUNERAL DIRECTOR NAME C. E. HICKS III | | ADDRESS 1922 Forest Drive | | 24b. REGISTRAR'S SIGNATURE <i>Anthony M. Kennedy</i> | |

1950

JANUARY 01 1951

RECEIVED

MAIL

1951

STATE WINDMILL COUNTY

STATE WINDMILL HOSPITAL

STATE WINDMILL

STATE WINDMILL HOSPITAL

STATE WINDMILL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 1 | 00 | 46 |
|--|--|--|--|---|---|---|---|--|--|--|---|----|----|
| 1. FOR STATE REGISTRAR | | | | | CERTIFICATE OF DEATH | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) DANIEL D. FABY | | | | | 2a. DATE OF DEATH MONTH 1 DAY 27 YEAR 81 | | | | | 2b. HOUR 2:05 P M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH 2 DAY 7 YEAR 27 | | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) N. Arundel Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accounts Chief | | 12b. KIND OF BUSINESS OR INDUSTRY State of Md. | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET ADDRESS 7469 Furnace Branch | | | |
| 13a. STATE Md. | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Glen Burnie | | | | | | | | | |
| 14. FATHER'S NAME FIRST Frank MIDDLE LAST Faby | | | | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE R. LAST Bunk | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 220-24-8980 | | 17. INFORMANT ADDRESS | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yes | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Old Poliomyelitis & marked secondary hypocalcemia and muscle wasting. Hypertension. | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 4/100 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 5/2/1959 to 1/27/1981 that (I) (we) last saw the deceased alive on 1/26/1981 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Albert B Bradley | | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED 1/29/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALBERT B. BRADLEY, M.D. | | | | | 22e. ADDRESS 4900 Belair Rd. Balto., Md. 21206 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 1/28/81 | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board ADDRESS Balto., Md. | | | | | 25. DATE REC'D. BY REGISTRAR FEB 3 1981 | | 25b. SIGNATURE Albert B Bradley | | | | | | |

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE IN PENCIL IN ITEM 18, "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGES 4 AND 5 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 00147 | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) HOLLY Ann FALETTA | | | | | | | | | | 2b. HOUR 7 M | |
| 3. SEX F 4. RACE W 5. DATE OF BIRTH MONTH 1 DAY 13 YEAR 75 6. AGE (IN YEARS) LAST BIRTHDAY 6 YRS. | | | | | | | | | | 7c. DATE PRONOUNCED DEAD MONTH 1 DAY 24 YEAR 1981 2d. HOUR 9 M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Taiwan 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH Glen Burnie 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student 12b. KIND OF BUSINESS OR INDUSTRY Kindergarten | | | | | | | | | | | |
| 13a. STATE Maryland 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Pasadena 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 116 Wileys Lane 21122 | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST Peter MIDDLE Faletto, Jr. LAST Smith 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Smith LAST Smith | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. None 17. INFORMANT ADDRESS Mr. Peter Faletto, Jr. Same as #13 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8121 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. multiple injuries (b) multiple injuries (c) multiple injuries | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION 1/23/81 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Auto & Auto Collision 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH PM 1 23 81 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM 1 23 81 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Auto & Auto Collision | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK Highway 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Highway 21f. LOCATION STREET Hammonds Ferry & Poplar Rd CITY OR TOWN Hammonds Ferry COUNTY Anne Arundel STATE MD | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE E. Linhardt TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 1. 24. 81 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) E. Linhardt ADDRESS Annapolis Md | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPEC) Burial 23b. DATE 1/27/1981 23c. NAME OF CEMETERY OR CREMATORY Smith Family Cemetery 23d. LOCATION CITY OR TOWN Severn COUNTY Anne Arundel STATE Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Mc Cully F.H. Mtn & Tick Neck Rds., Pasadena, Md. ADDRESS 21122 25a. DATE REC'D. BY REGISTRAR JAN 27 1981 25b. REGISTRAR'S SIGNATURE L. J. H. H. H. | | | | | | | | | | | |

[Faint handwritten notes at the bottom of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8100148 | | | |
|--|-------------------------------------|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVA B. FLETCHER | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/1/81 | | 2b. HOUR 7:30 AM | | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 2-22-25 | | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH A-A-C. | | | |
| 10. CITY OR TOWN OF DEATH SEVERNA Pk | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 111 Loch Leven Dr. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EXECUTIVE SECRETARY - Schools | | 12b. KIND OF BUSINESS OR INDUSTRY MD. | |
| 13a. STATE Md | | 13b. COUNTY AA | 13c. CITY OR TOWN Severna Pk | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST OSCAR BENHART | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST WALLY BENKERT | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578242102 | | 17. INFORMANT ADDRESS Daniel W. Fletcher - Phone | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca BREAST</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1978, 19, to 1/1/81, 19, that (I) (we) lost saw the deceased alive on 12/30/80, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Stanley P. Watkins Jr | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/1/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY P. WATKINS JR | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 1-2-81 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Cmn | | 23d. LOCATION CITY OR TOWN COUNTY STATE Westview Balt Md | |
| 24. FUNERAL DIRECTOR NAME Robert S. Baranows | | ADDRESS Severna Pk | | 25a. DATE REC'D. BY REGISTRAR JAN 5 1981 | | 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (must be notified)

#8, Film 551 1/26/81 kam

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8100149

| | | | | | |
|--|--|--|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES L FOWLER | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 5 81 | | 2b. HOUR 10²⁵ PM |
| 3. SEX MALE | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 4 17 43 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 37 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber - Retired | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD | | 13b. COUNTY ANNE ARUNDEL | 13c. CITY OR TOWN EDGEWATER | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 311 OAKWOOD RD |
| 14. FATHER'S NAME FIRST MIDDLE LAST JAMES E. Fowler | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thelma E. Hopkins | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216-42-1437 | | 17. INFORMANT Julia L. Fowler | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1719 IMMEDIATE CAUSE (a) Metastatic Sarcoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from August 10 , 19 1980 , to JAN 5 , 19 81 , that (I) (we) last saw the deceased alive on 115 , 19 81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Enser W. Cole Jr | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/6/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ENSER W. COLE JR | | 22e. ADDRESS 121 CATHEDRAL ST ANNAP. Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 01-08-81 | | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis, Anne Arundel, Md. | | 24. FUNERAL DIRECTOR NAME Beall Funeral Home, 1212 West St., Anna., Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1981 | |
| 25b. REGISTRAR'S SIGNATURE Patricia McCreedy | | | | | |



RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8100150 EST | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) JOHN HARVEY FRANKLIN | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 21, 1981 | | 2b. HOUR A 11:45 M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 19, 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance | | 12b. KIND OF BUSINESS OR INDUSTRY Transportation | |
| 13a. STATE Maryland | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harvey John Franklin | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude = Widerman | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW-2 | | 16b. SOCIAL SECURITY NO. 218-09-0684 | | 17. INFORMANT ADDRESS Frances R. Franklin same as above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5750 Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Acute gangrene of the DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1.2.81 | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION 1.20.81 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute congestive heart failure | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1.21.81 to 1.21.81 , that (I) (we) last saw the deceased alive on 1.21.81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Arsenio Santos | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARSENIO SANTOS, M.D. | | 22e. ADDRESS 7845 OAKWOOD RD., GLEN BURNIE, MARYLAND 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/24/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A. A. Md. | |
| 24. FUNERAL DIRECTOR NAME Raymond C. Fink | | ADDRESS Glen Burnie, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 23 1981 | | 25b. REGISTRAR'S SIGNATURE Robert H. ... | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8100151 | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | | 2b. HOUR | | | |
| Rosalie A FRIES | | | | January 5 1981 650 P.M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| F | | W | | Aug 14 1904 | | 76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| BALTO. Md. | | USA | | | | Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Annapolis | | Anne Arundel Gen. | | ASSEMBLY LABOR | | WINDOW CO. | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| MARYLAND | | A.A. | | EDGEWATER | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 13e. STREET ADDRESS | | | |
| FRANCIS RAESLER | | CATHERINE | | 1625 FULLERTON Rd. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | |
| NO | | 219-20-5977 | | LEATHA PRICE | | #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 2041 Aspiration pneumonia | | | | | | | 10 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | - |
| Chronic Lymphatic Leukemia | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | 3 mi. W. of | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-5-81, to 1-5-81, that (I) (we) last saw the deceased alive on 1-5-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| Stanley P. Watkins | | | | M.D. | | 1/5/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| STANLEY P. WATKINS | | | | 121 CATHEDRAL ST - ANNAPOLIS Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| BURIAL | | 1-8-81 | | CEDAR HILL | | BROOKLYN A.A. | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| BARRANCO | | RITCHIEWAY PARK Md. | | JAN 12 1981 | | Ritchie Way | |

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1-2-81

STANLEY D. WALKER

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JAN 1 1981

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1. FOR
STATE
REGISTRARDEPARTMENT OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|---|-----------------------------------|-----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Viola D. Gardner | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 23 81 | | | 2b. HOUR 920 A M | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 5 11 17 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Beautician | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md. | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 111 Georgia Ave. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Davies | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola Lynch | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 212-14-2441 | | 17. INFORMANT ADDRESS | | | | | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ON CALL CA 4 Lm 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 min | |
|---|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/23 19 81 , to 1/23 19 81 , that (I) (we) lost saw the deceased alive on 1/23 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE R. Breen for S. Smith | | | | DEGREE | | 22c. DATE SIGNED 1/24/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert O. Bie RN | | | | 22e. ADDRESS 121 Cathedral Street | | | |

| | | | | | | | |
|--|--|--------------------------|--|------------------------------------|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 1/24/81 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
|--|--|--------------------------|--|------------------------------------|--|---|--|

| | | | | | | | |
|--|--|----------------------------|--|--|--|--|--|
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 28 1981 | | 25b. REGISTRAR'S SIGNATURE R. Breen | |
|--|--|----------------------------|--|--|--|--|--|



Sanitation

111 Georgia Ave.

London

Yield

Yield

Yield

1911-1912

1911

1911

Yield

1911

1911

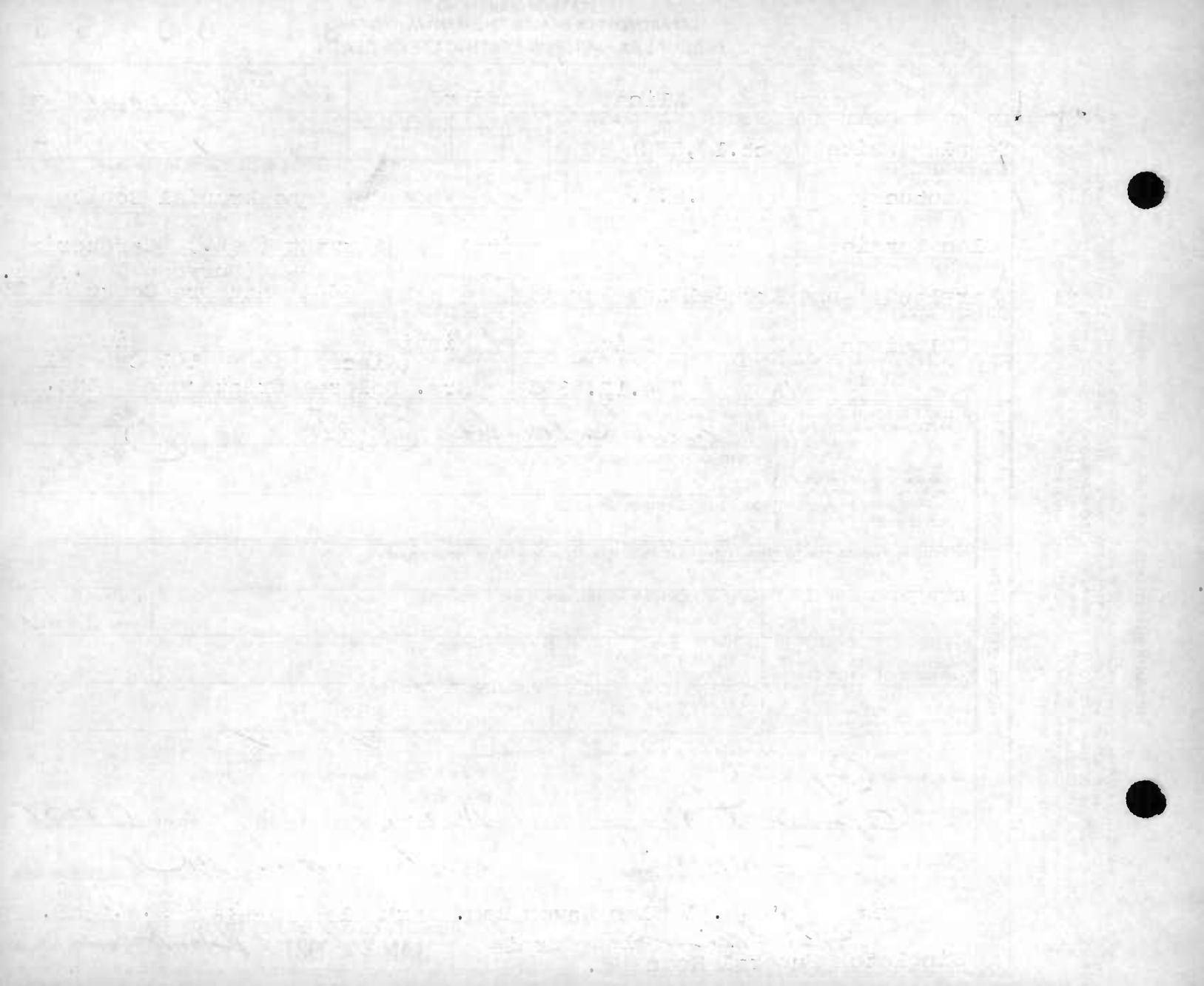
Yield

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 3 1 00153 | | | | | | | | | |
|---|--|---------|--|---|--|-------------------|--|--|--|---|--|---|--|-----------|--|-----------------------------------|--|----------|--|--|--|---------------|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| Snowy Alice Goddard | | | | | | | | | | 1 22 1981 | | | | | | | | | | A M | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 1 YR. | | 8. IF UNDER 24 HRS. | | 9. DATE PRONOUNCED DEAD | | 10. MONTH | | 11. DAY | | 12. YEAR | | 13. HOUR | | 14. MIN. | | | | | | | |
| Female | | White | | Oct. 19, 1900 | | 80 YRS. | | | | | | 1 22 1981 | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | | | |
| Kentucky | | | | U.S.A. | | | | | | | | Anne Arundel County MD. | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Glen Burnie | | | | 6644 Whitmore Court | | | | | | | | Servant (Ret.) | | | | Cafeteria | | | | | | | | | | | | | |
| 13a. STATE | | | | 13b. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | | 13f. APT. NO. | | | | | | | | | | | | | |
| Maryland | | | | Anne Arundel | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 6644 Whitmore Court Bl 31 | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | 18. ADDRESS | | | | | | | | | | | | | |
| Culbeison | | | | Smith | | | | 294.12.8395 | | | | Mrs. Dolores Greathouse | | | | 101 Cromwell Ave. (21061) | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | 18. ADDRESS | | | | 19. DATE | | | | | | | | | | | | | |
| No | | | | N/A | | | | 294.12.8395 | | | | Mrs. Dolores Greathouse | | | | 1.22.81 | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4292 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| | | | | | | | | | | P.M. 19 | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | 21f. LOCATION | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from | | | | | | | | | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | TITLE (SPECIFY) | | | | | | | | | | DATE SIGNED | | | | | | | | | |
| E. L. W. H. A. R. C. H. | | | | | | | | | | M.D. Depose | | | | | | | | | | 1.22.81 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Singleton Funeral Home Md. | | | | | | | | | | JAN 27 1981 | | | | | | | | | | A.A. MD. | | | | | | | | | |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH: 16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

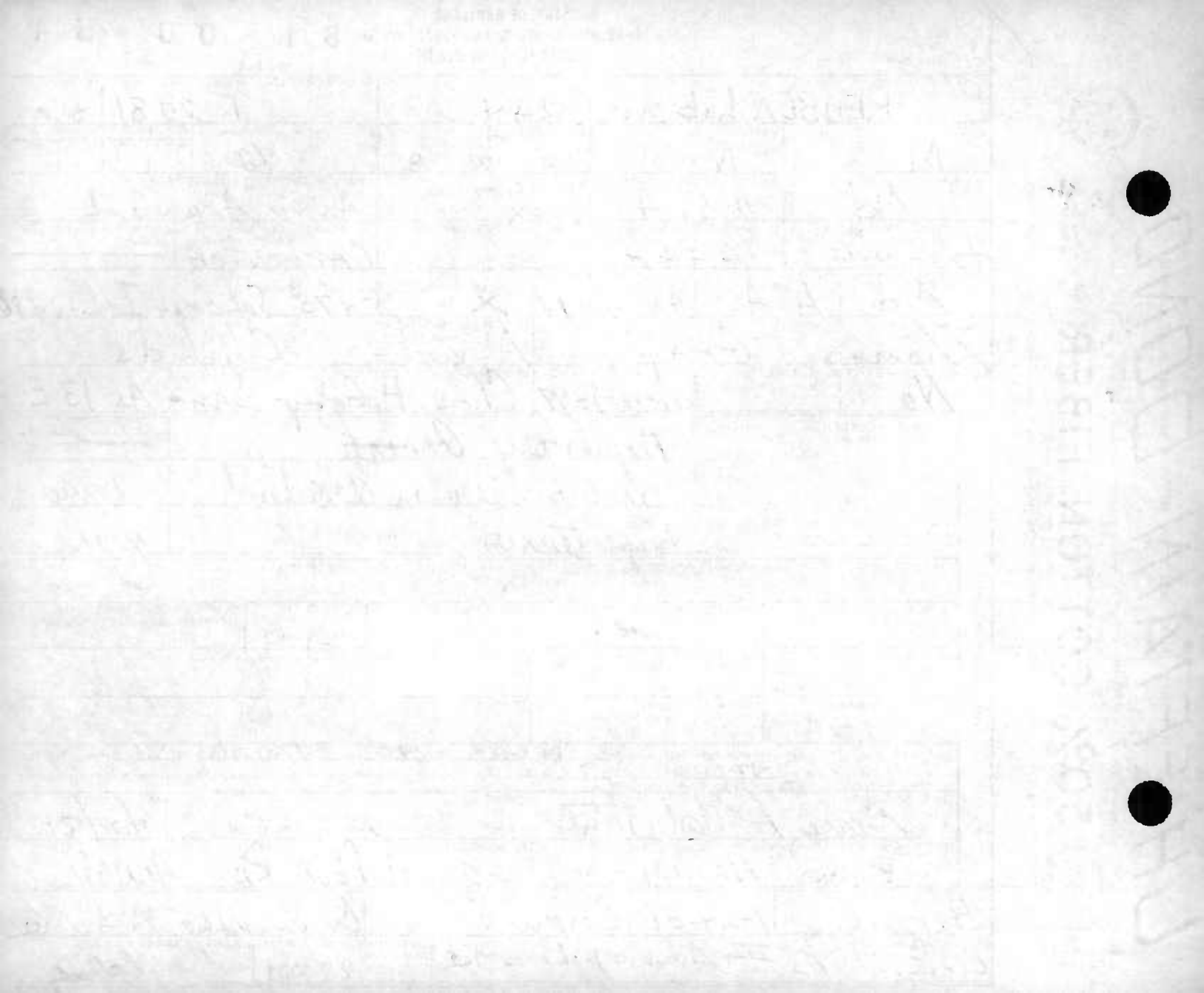
REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) REUBEN Lubine GRAY | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 20 81 | | | 2b. HOUR 3 P.M. | | | |
| 3. SEX M | | 4. RACE N | | 5. DATE OF BIRTH MONTH DAY YEAR 06 08 98 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Annap Arundel MD. | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AAGH | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13a. STATE Md | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Annapolis | | 13e. STREET ADDRESS 2473 Solomon Island Rd | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas GRAY | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alberta Childs | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217-16-1847 | | 17. INFORMANT ADDRESS Chas. H. Gray - Same As 13E | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (1) (this individual)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebro-vascular accident DUE TO, OR AS A CONSEQUENCE OF (c) hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo. years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DEC 13, 19 80 , to JAN 20, 19 81 , that (I) (we) lost saw the deceased alive on JAN 20, 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Barry P. Nathanson | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/21/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY NATHANSON | | | | | | 22e. ADDRESS 2568A PIVA RD. ANNAP. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 1-24-81 | | 23c. NAME OF CEMETERY OR CREMATORY Chews | | 23d. LOCATION CITY OR TOWN COUNTY STATE Owensville A.A. Md | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS C.E. Hicks III Annapolis-Md | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 27 1981 | | 25b. REGISTRAR'S SIGNATURE Barry P. Nathanson | |

MEDICAL CERTIFICATION

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21
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8100155 E.S.T. | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE | |
| | | GEORGE ALBERT GRIBBLE | | Male | | White | |
| 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | |
| 7. MONTH DAY YEAR | | 67 YRS. | | Pa. | | U.S.A. | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | |
| | | ANNE ARUNDEL COUNTY MD. | | GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS | | 13b. INSIDE CITY LIMITS? | |
| Operating Engineer | | Construction | | 354 Ridge Rd. 21122 | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| Charles R. Gribble | | Viola May Metz | | No | | 213-10-4188 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| Genevieve Gribble same as 13 | | PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Condi pulmonary arrest</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Probable MI</u> (c) <u>Due to, or as a consequence of</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | |
| ASHD - | | | | HOUR A.M. MONTH DAY YEAR | | | |
| | | | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | 21g. LOCATION | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1.6.1981 to 1.6.1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I) (we) did not view the body after death. | | 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | |
| | | DEGREE | | 1.29.81 | | CENAP DORKAN, M.D. | |
| | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22e. ADDRESS | | 22f. ADDRESS | |
| | | | | 325 HOSPITAL DRIVE | | GLEN BURNIE, MARYLAND 21061 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | 1/31/1981 | | Meadowridge Mem. Park | | Dorsey Howard Md. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | 25c. REGISTRAR'S SIGNATURE | |
| NAME | | FEB 3 1981 | | Rafael McBrady | | | |
| Mc Cully F. H. Mountain & Tick Neck Rds. 21122 | | | | | | | |

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

TO : DIRECTOR, FBI (100-388610)
FROM : SAC, ALBANY (100-100000)
SUBJECT: [Illegible]

DATE: JANUARY 28, 1981
TIME: 10:15 AM

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8100156 | |
|--|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | CERTIFICATE OF DEATH | | REG. NO. EST | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSEMARY H. GRIMES | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 8, 1981 | | 2b. HOUR P M 4:43 P M |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 2 13 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 70 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PUERTO RICO | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTING CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY UNIVERSITY |
| 13a. STATE MARYLAND | | | 13b. COUNTY A.A. | 13c. CITY OR TOWN SEVERNA PARK | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST ARTHUR L. HUNSDON | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY C. VAN WINKLE | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 136-20-6073 | | 17. INFORMANT ADDRESS ARTHUR H. GRIMES 217 SYCAMORE RD SEVERNA PARK, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) vent. fibrillation DUE TO, OR AS A CONSEQUENCE OF (b) ASHD acute MI DUE TO, OR AS A CONSEQUENCE OF (c) ASHD | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4100 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Ca of lung | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19 | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/7/80 , 19 80 , to 1/8 , 19 81 , that (I) (we) lost saw the deceased alive on 1/8 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE DEGREE James Benjamin MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) James J. Benjamin | | | | 22e. ADDRESS North Arundel Hosp | |
| 23a. BURIAL, CREMATION, REMOVAL CREMATION | | 23b. DATE 1-12-81 | | 23c. NAME OF CEMETERY OR CREMATORY Westmoreland Crematory | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Westmoreland Baltimore MD | | 24. FUNERAL DIRECTOR NAME ADDRESS John A. Bananas Severna Park | | | |

MEDICAL CERTIFICATION



2025 COLLECTION
HILLMAN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must notify the State Dept. of Health and Mental Hygiene.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 0 0 1 5 7 | | | |
|---|--|----------------------|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ORPHAY AMELIA | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 13, 1981 | | | |
| 3. SEX Female | | | | 2b. HOUR 2 P.M. | | | |
| 4. RACE White | | | | 5. DATE OF BIRTH MONTH DAY YEAR March 23 1882 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS. | | | |
| 7b. CITIZEN OF WHAT COUNTRY? United States | | | | 8. IF UNDER 1 YEAR MONTHS DAYS | | | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland Manor Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Grocery Store | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY Self-Emp. | | | | | | | |
| 13a. STATE MARYLAND | | | | 13b. CITY OR TOWN 412 "N" Street S.E. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL OGLE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA GROVE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 215-07-7649 | | | |
| 17. INFORMANT Daughter - in-law Same as # 13 | | | | Mrs. Catherine C. Gundling | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio Vascular Disease with old Cardio Vascular Accident 4292 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (If this hospital) attended the deceased from July 29, 1977, to January 13, 1981, that (we) last saw the deceased alive on January 13, 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (th) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Peter H. Rheinstein, MD | | | | DEGREE | | 22c. DATE SIGNED Jan 13, 1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER H. RHEINSTEIN, MD | | | | 22e. ADDRESS MARYLAND MANOR NURSING HOME | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 16 JAN. 81 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Park, A.A., MD. | |
| 24. FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME | | | | 24b. ADDRESS Glen Burnie, Maryland | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1981 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

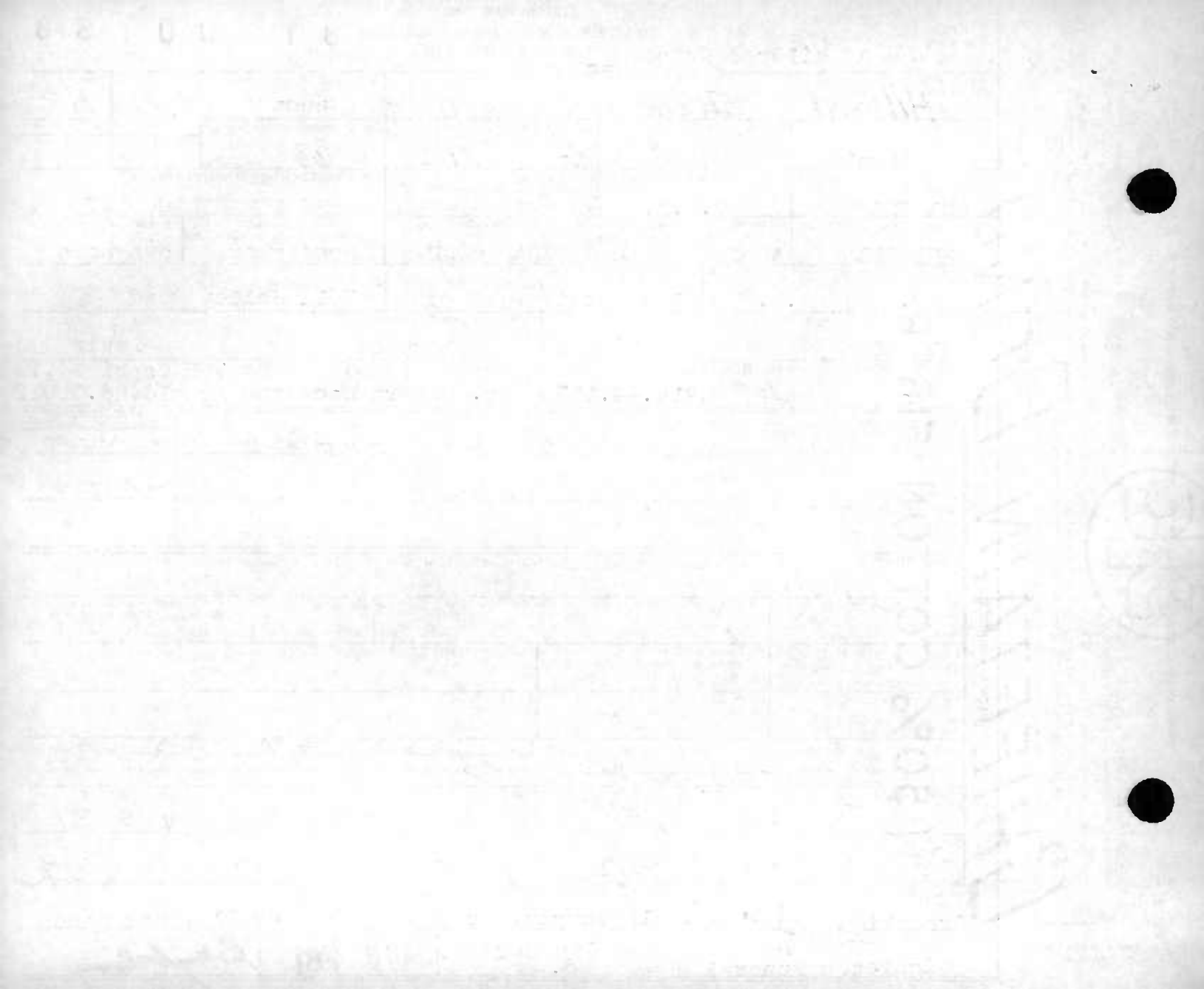
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

MEDICAL CERTIFICATION

| FOR 1- STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 1 0 0 1 5 8 | |
|--|--|---|--|---|--|
| Mildred Irene HACKMANN | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Mildred Irene HACKMANN | | 2a. DATE OF DEATH MONTH DAY YEAR January 5, 81 | | 2b. HOUR 11 AM | |
| 3. SEX Female | 4. RACE Cauc | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 4, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSP. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY own home |
| 13a. STATE Md. | | 13b. COUNTY A.A. | 13c. CITY OR TOWN Glen Burnie | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN Clipper | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Lewis | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214.44.1570 | | 17. INFORMANT (Son) ADDRESS Mr. Robert Hackmann Arnold, Md. 21012 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST 2396 DUE TO, OR AS A CONSEQUENCE OF (b) BRAIN TUMOR DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN 4 MONS | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) NONE | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 28 NOV , 19 80 , to JAN , 19 81 , that (I) (we) last saw the deceased alive on JAN , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Pete Schilber | | DEGREE MD | | 22c. DATE SIGNED 1-5-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER SCHILBER | | 22e. ADDRESS 25 SHAW ST ANNAPOLIS MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 6 JAN. 81 | | 23c. NAME OF CEMETERY OR CREMATORY Security Process | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Maryland | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1981 | | | |
| 24. FUNERAL DIRECTOR NAME Singleton Funeral Home | | ADDRESS Glen Burnie, Md. | | 25b. REGISTRAR'S SIGNATURE Robert Hackmann | |

BP



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|--|--|------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) HUGH W HAMMERLE | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 2 81 | | | 2b. HOUR 6 ¹⁵ AM | | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 12, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Bus driver | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | | | | | |
| 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Edgewater | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1503 Mayfield Rd. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry W. Hammerle | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Schneider | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT Mary R. Hammerle | | ADDRESS same as 13e | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive myocardial infarction</u> 4415 DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypovolemic shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ruptured aortic aneurysm</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours 6 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 19a. DATE OF OPERATION 1-1-81 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED above | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>1-1</u> , 19 <u>81</u> , to <u>1-2</u> , 19 <u>81</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>1-2</u> , 19 <u>81</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did) <u>(did not)</u> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Karl R. Holschuh | | | DEGREE MD | | | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN | | 22c. DATE SIGNED 1-2-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KARL HOLSCHUH | | | 22e. ADDRESS 104 Forbes St. Annapolis | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial-transit | | 23b. DATE Jan. 6 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Hollywood Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pittsburgh, Pennsylvania | | | |
| 24. FUNERAL DIRECTOR NAME Beall Funeral Home, 1212 West St., Anna., Md. | | | 25. DATE RECEIVED BY REGISTRAR JAN 7 1981 | | 25b. REGISTRAR'S SIGNATURE | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove this certificate from the file and place it in the file of the deceased with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 0 1 6 0 | | | |
|--|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | | |
| SARAH VIRGINIA HANLEY | | | | JANUARY 16, 1981 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE | |
| FEMALE | | WHITE | | MAY 9, 1901 | | 79 | |
| 7a. BIRTHPLACE | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MARYLAND | | U.S.A. | | NEVER MARRIED | | ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | HOMEMAKER | | OWN HOME | |
| 13a. STATE | | | | 13b. CITY OR TOWN | | | |
| MARYLAND | | | | ANNE ARUNDEL MILLERSVILLE | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | |
| FRANK | | | | CHARLOTTE MARTIN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | | |
| NO | | | | 214-38-0497 | | | |
| 17. INFORMANT | | | | ADDRESS | | | |
| MRS. DORIS TEPPER (DAUGHTER) | | | | Same as # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (b) SHOCK | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) CVA - BRAINSTEM INFARCTION | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | | |
| (IF EITHER, NOTIFY MEDICAL EXAMINER) | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/10, 19 81, to 1/16, 19 81, that (I) (we) last saw the deceased alive on 1/16, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| SURYA P. MUNDRA | | MD | | 1/16/81 | | | |
| 22d. PHYSICIAN'S NAME | | 22e. ADDRESS | | 22f. PHYSICIAN'S SIGNATURE | | | |
| SURYA P. MUNDRA | | 1028 Rustling Oaks Dr Millersville MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| (SPECIFY) BURIAL | | 19 JAN '81 | | GLEN HAVEN MEM. PK. | | GLEN BURNIE A.A. MD. | |
| 24. FUNERAL DIRECTOR | | 24a. DATE REC'D. BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | | |
| SINGLETON FUNERAL HOME, GLEN BURNIE, MD. | | JAN 19 1981 | | F. J. HANLEY | | | |

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 00161 | |
|---|------------------|--|---|--|---|---|--|--|--|----------------|--|
| 1- STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) HARRY HART | | | | | | 2a. DATE KNOWN OF DEATH ESTI-MATED 8 1 2 1981 | | 2b. HOUR 10 AM | | | |
| 3. SEX M | 4. RACE N | 5. DATE OF BIRTH MONTH DAY YEAR 8 23 1916 | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD 1 2 1981 | | 2d. HOUR P AM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hosp. & L | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY Railroad | | | |
| 13a. STATE New Jersey | | | | 13c. CITY OR TOWN Oceanport | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Monmouth Park Racetrack | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST 3AIL HART | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes (IF YES, GIVE WAR OR DATES) WWII | | | | 16b. SOCIAL SECURITY NO. 172-14-1252 | | 17. INFORMANT ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Cerebrovascular C.D.S. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Thunder | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE E. Linhardt | | | TITLE (SPECIFY) M.D. Repodg | | | MEDICAL EXAMINER | | DATE SIGNED 1-2-81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) E. Linhardt | | | ADDRESS Annapolis, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | | 23b. DATE 1/9/81 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Anatomy Board Balto., Md. | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 26 1981 | | 25b. REGISTRAR'S SIGNATURE Anthony McCreedy | | | | |

MEDICAL CERTIFICATION



Belmont

Mount Pleasant Park

Belmont

Belmont

Belmont

Belmont

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as required by law.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 0 1 6 2 E.S.T. | |
|---|---|---|---|--|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FANNIE V. HAY | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 6, 1981 | | 2b. HOUR 6:45 AM |
| 3. SEX FEMALE | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 12, 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE Md. | 13b. COUNTY AA | 13c. CITY OR TOWN Glen Burnie | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 104 Chalmers Ave., Ferndale | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles C. Griffith | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Knight | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Donald Hay, Husband, same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-9-80</u> to <u>1-6-81</u> , that (I) (we) lost saw the deceased alive on <u>1-5-81</u> 19 <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Jack I. Stern</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-6-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JACK I. STERN, M.D. | | 22e. ADDRESS 300 HOSPITAL DRIVE SUITE 135 GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9 Jan. 81 | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, AA, Md. | |
| 24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie | | 25a. DATE REC'D. BY REGISTRAR JAN 9 1981 | | 25b. REGISTRAR'S SIGNATURE <u>Johny McKelvey</u> | |

(M)



James A. Kirkley, 1111
1015 251

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8100163 | |
|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAYMOND EARL HEAGNEY | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 2 81 | | 2b. HOUR 3:45 PM | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 11 21 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | | IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) R.I. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED (RET.) | | 12b. KIND OF BUSINESS OR INDUSTRY STEEL IND. | | | |
| 13a. STATE R.I. | | 13b. COUNTY PROVIDENCE | | 13c. CITY OR TOWN PAWTUCKET | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 255 GRAND AVE. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JAMES B HEAGNEY | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IRENE WILLIAMS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 035-05-9417 | | 17. INFORMANT ADDRESS PHYLLIS P. HEAGNEY (wife) Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral infarction DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular standstill DUE TO, OR AS A CONSEQUENCE OF (c) Acute myocardial infarction CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4100 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Minutes Minutes | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/30 , 19 80 , to 1/2 , 19 81 , that (I) (we) lost saw the deceased alive on 1/2 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE E. Barnes | | | | DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/2/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GENNAN CHURCH | | | | 22e. ADDRESS 8 GUNNENSON ROAD SOVERA PARK MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 1-6-81 | | 23c. NAME OF CEMETERY OR CREMATORY ST. FRANCIS | | 23d. LOCATION CITY OR TOWN COUNTY PAWTUCKET R.I. | | | |
| 24. FUNERAL DIRECTOR NAME FLEMING FUNERAL SERVICE | | | | ADDRESS BENSON MD | | 25a. DATE REC'D. BY REGISTRAR JAN 6 1981 | | 25b. REGISTRAR'S SIGNATURE R. H. H. H. | | | |

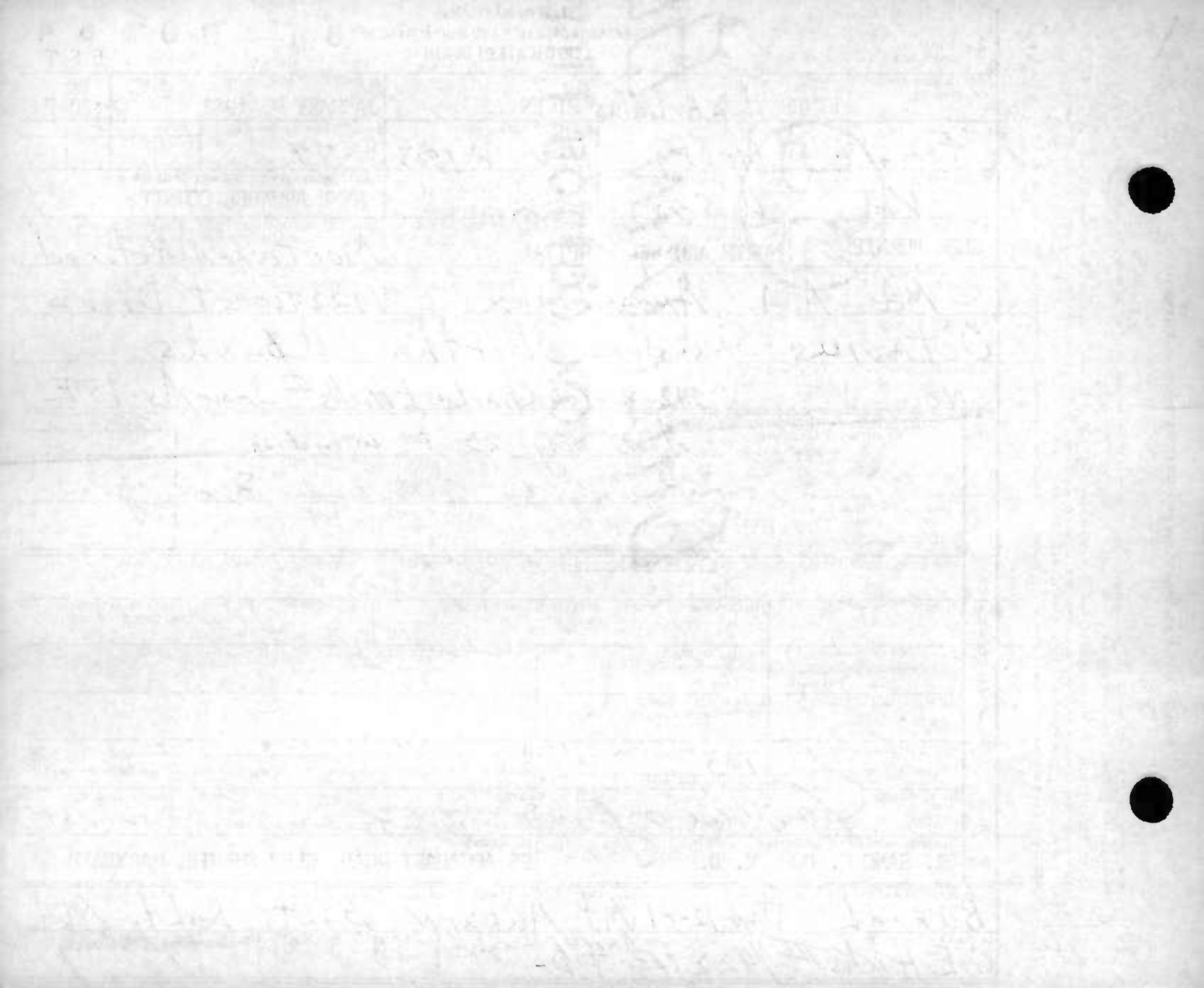
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (must be notified at 833-3435).

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|---|---|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 8 1 0 0 1 6 4 EST | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | |
| ETHEL LA ARBUTUS HICKS | | | | | JANUARY 9, 1981 | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | | |
| Female | | Negro | | Nov. 8-1903 | | 77 | | 6:20 PM | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. MD | | |
| VA. | | U.S.A. | | | | ANNE ARUNDEL COUNTY | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | | | Mortician | | Retired | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | | 13d. INSIDE CITY LIMITS? | |
| Md. A.A. ANNAPOLIS | | | | | ANNAPOLIS | | 1922 Forest Drive | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | | | | |
| OCTAVIUS SAUNDERS | | | | | BERTHA U BANKS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | | | | 612-36 6480 | | Charles E. Hicks III SAME AS 13E | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic atherosclerotic Cardiovascular Disease years</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-9</u> , 19 <u>81</u> , to <u>1-9</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>1-9</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | 22b. SIGNATURE <u>Don Clue of MD</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED <u>1-10-81</u> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. SANG C. DOH, M. D. | | | 22e. ADDRESS 95 AQUAHART ROAD, GLEN BURNIE, MARYLAND | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | JAN 12-81 | | Mt Auburn | | BALT Md | | | |
| 24. FUNERAL DIRECTOR NAME | | | 24b. ADDRESS | | 25a. DATE RECD. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| C.E. Hicks III | | | 1922 Forest Dr. | | JAN 19 1981 | | <u>[Signature]</u> | | | |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 0 1 6 5

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|--|---------|---|--|--------------------------------------|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| FIRST MIDDLE LAST Frances Hopkins Hill | | | MONTH DAY YEAR January 19, 1981 | | | 3 P.M. | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE | | 7. BIRTHPLACE | | |
| Female | White | Oct 27 1886 | | 94 | | Annapolis, Md. | | |
| 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | |
| U.S. | | NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | Anne Arundel MD | | Edgewater | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | | 12. USUAL OCCUPATION | | | 13. KIND OF BUSINESS OR INDUSTRY | | |
| 29 S. RIVER RD. South | | | HOME | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. SOCIAL SECURITY NO. | | |
| Harry J. Hopkins | | | Frances R. Chatthe | | | 216-46-6922 | | |
| 17. IF DECEASED EVER IN U.S. ARMED FORCES | | | 18. CAUSE OF DEATH | | | 19. IF DECEASED EVER IN U.S. ARMED FORCES | | |
| NO | | | Arteriosclerotic Heart Disease | | | NO | | |
| | | | Generalized Arteriosclerosis | | | | | |
| | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| Generalized Arthritis | | | | | | | | |
| 20a. DATE OF OPERATION | | | 20b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20c. AUTOPSY? | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED | | |
| OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | HOUR A.M. MONTH DAY YEAR | | | ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2 | | |
| (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | P.M. 19 | | | NO injury | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | | 21f. LOCATION | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | CITY OR TOWN COUNTY STATE | | |
| | | | | | | Lothian, Maryland | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/29/81, 1977, to 1/19, 1981, that (I) (we) last saw the deceased alive on 1/19/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | 22d. PHYSICIAN'S NAME | | |
| Charles H. Wirth MD | | | 1/19/81 | | | Charles H. Wirth MD | | |
| 22e. PHYSICIAN'S NAME | | | 22f. ADDRESS | | | 22g. DATE REC'D. BY REGISTRAR | | |
| Charles H. Wirth MD | | | Lothian, Maryland 20820 | | | JAN 22 1981 | | |
| 22h. BURIAL, CREMATION, REMOVAL | | | 22i. DATE | | | 22j. NAME OF CEMETERY OR CREMATORY | | |
| CREMATION | | | 1/20/81 | | | H. Lincohan | | |
| 22k. LOCATION | | | 22l. CITY OR TOWN | | | 22m. COUNTY | | |
| Brentwood P.G. Md. | | | | | | | | |
| 22n. FUNERAL DIRECTOR | | | 22o. DATE REC'D. BY REGISTRAR | | | 22p. REGISTRAR'S SIGNATURE | | |
| John M. Lister Camp, Md. | | | JAN 22 1981 | | | [Signature] | | |

MEDICAL CERTIFICATION

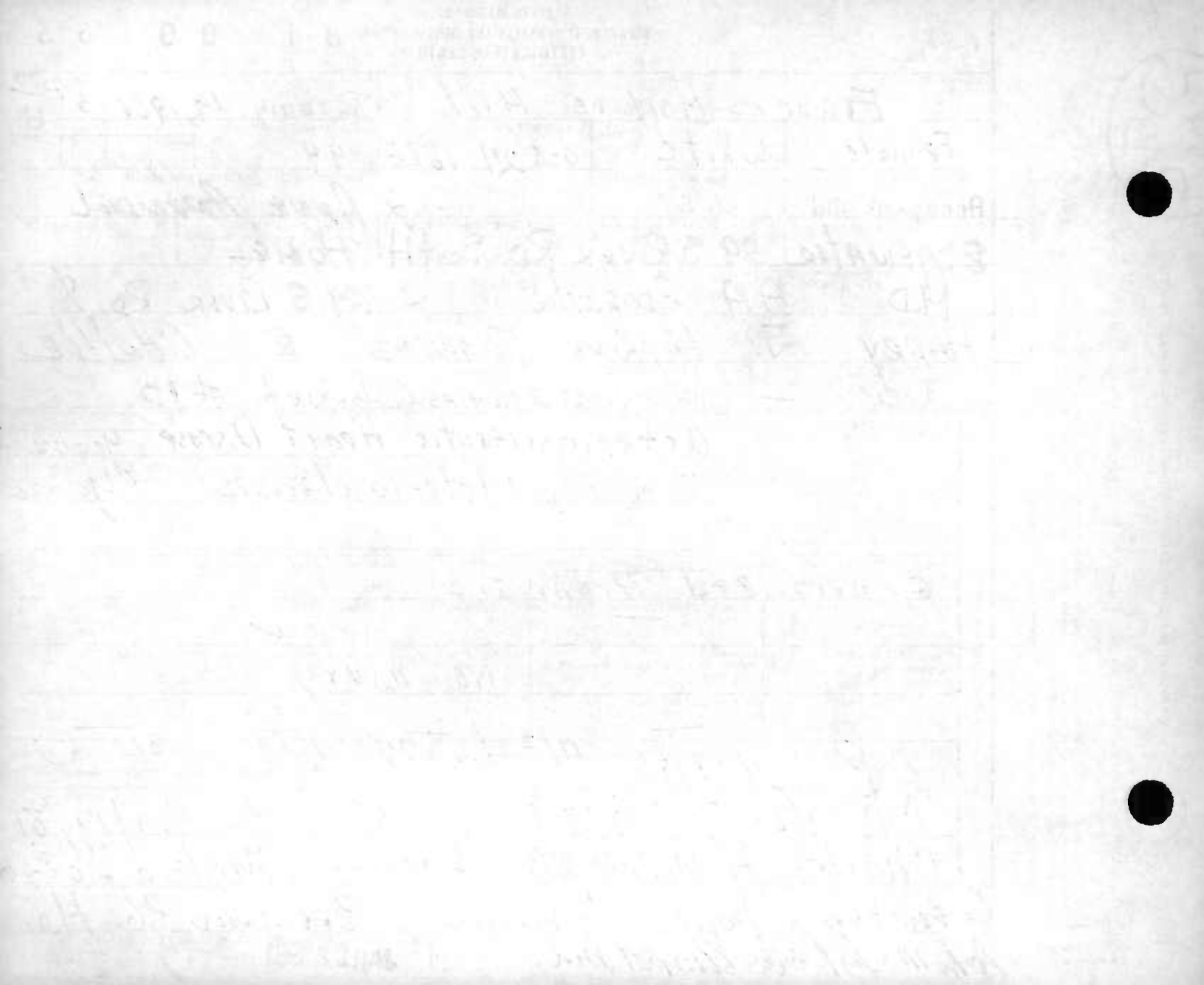
29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 1 | 0 | 0 | 1 | 6 | 6 |
|---|--|---|--|---|--|--|--|--|--|---|---|---------------------|---|----------|---|---|
| 1 - FOR STATE REGISTRAR | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | |
| I. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | |
| FIRST MIDDLE LAST MARGARET PAULINE HOLMES | | | | | | | | | | MONTH DAY YEAR JANUARY 15, 1981 | | | | 345P M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | | |
| Female | | White | | MONTH DAY YEAR April 15, 1909 | | 71 YRS. | | MONTHS DAYS | | HOURS MIN. | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | |
| Maryland | | U.S.A. | | | | ANNE ARUNDEL MD. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | | | Bookkeeper | | Banking | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland A. A. Lake Shore | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 8437 Garland Road | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John A. Bull | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE Lilly Kohler | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | | | | |
| no | | | | 215-30-0490 213-28-5676-D | | Bernard J. Holmes Jr. same as above | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic CVD DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 years | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CVA & right hemiplegia 4 years | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from saw the deceased alive on January 14, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not know the body after death.) | | | | July 10, 1952, to January 15, 1981 | | | | | | | | | | | | |
| 22b. SIGNATURE R. M. McLaughlin, M.D. | | | | DEGREE | | | | 22c. DATE SIGNED 1/16/81 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. RANDALL MCLAUGHLIN MD. | | | | 22e. ADDRESS 3708 MOUNTAIN RD. PASADENA MARYLAND 21122 | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1/17/81 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A. Md. | | | | | | |
| 24. FUNERAL DIRECTOR NAME Raymond C. Fink | | | | ADDRESS Glen Burnie, Md. | | | | 25a. DATE RECEIVED BY REGISTRAR JAN 19 1981 | | 25b. REGISTRAR'S SIGNATURE | | | | | | |

WARGENT PAULINE EDGES JANUARY 18, 1981

April 15, 1982

White

White

U.S.A.

White

WHITE ARCADE HOSPITAL

WHITE ARCADE

A.A.

White

A.

White

11-12-82

White

7208 KENTLEY RD. PASADENA HAWAII 96785

7208 KENTLEY RD. PASADENA HAWAII 96785

11/1/1 Glen Haven Co. Glen Burnie, A.A. Md.

Glen Burnie, Md. Glen Burnie, Md.

TO HOSPITAL-ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner, medical examiner, or medical examiner should be consulted.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8100167 | |
|--|--|--|---|--|--|--|--|--|--|---------|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | 2c. MONTH DAY YEAR | | |
| 1 DECEASED NAME (TYPE OR PRINT) VELMA Eunice HOLSOOPPLE | | | 2a. DATE OF DEATH 1-30-81 | | | 2b. HOUR 1P | | | 2c. MONTH DAY YEAR | | |
| 3 SEX FEMALE | | | 4 RACE WHITE | | | 5 DATE OF BIRTH 9-14-01 | | | 6 AGE (IN YEARS LAST BIRTHDAY) 79 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD | | |
| 10 CITY OR TOWN OF DEATH Annapolis | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | |
| 13a. STATE Md. | | | 13b. COUNTY Anne Arundel | | | 13c. CITY OR TOWN Arnold | | | 13d. STREET ADDRESS 308 Jones Station Road | | |
| 14 FATHER'S NAME Lorenzo H. Fike | | | 15. MOTHER'S MAIDEN NAME Laura Myers | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 162-07-6184 | | |
| 17 INFORMANT Mr. C. Harold Holsoopple, Oakland, Md. 21550 | | | 18. ADDRESS | | | 19. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20. STREET ADDRESS | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months | | | 19. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21e. LOCATION STREET CITY OR TOWN COUNTY STATE | | | 22a. I certify that (I) (this hospital) attended the deceased from 12/20/80 to 1/30/81, that (I) (we) last saw the deceased alive on 1/30/81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | 22b. SIGNATURE ENDER W. COLE III MD | | |
| 22b. SIGNATURE ENDER W. COLE III MD | | | 22c. DATE SIGNED 1/30/81 | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ENDER W. COLE III | | | 22e. ADDRESS 121 CATHEDRAL ST ANNAP MD. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | | 23b. DATE 2/2/81 | | | 23c. NAME OF CEMETERY OR CREMATORY Gortner Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Oakland, Garrett, Maryland | | |
| 24 FUNERAL DIRECTOR NAME Bradley A. Stewart, Oakland, Maryland 21550 | | | 24b. ADDRESS 21550 | | | 25a. DATE REC'D. BY REGISTRAR FEB 9 1981 | | | 25b. REGISTRAR'S SIGNATURE Hofing, McCreedy | | |

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91 12 18 1

MT-116

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10 11 1



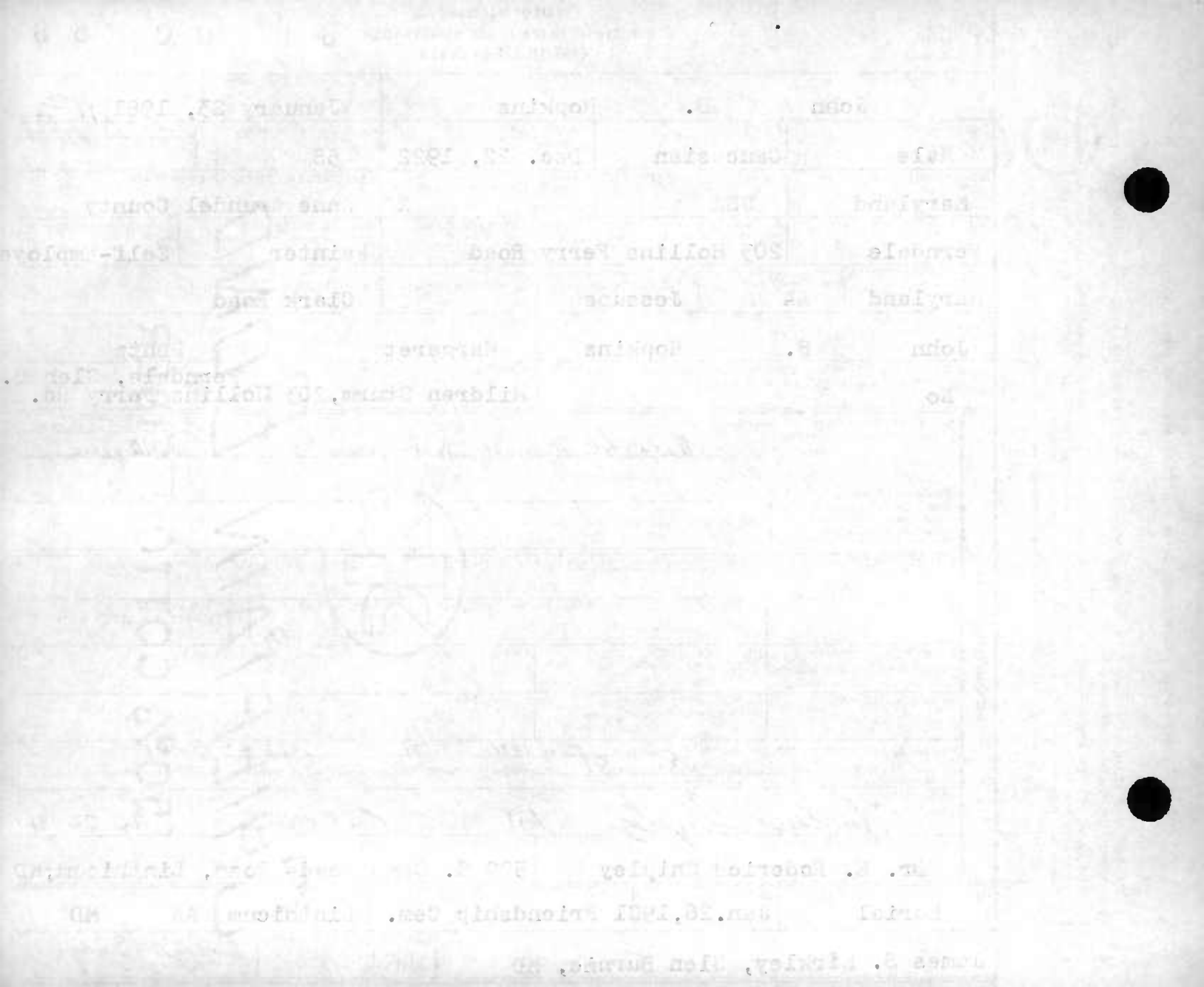
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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) John B. Hopkins | | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 23, 1981 | | | | | |
| 3. SEX Male | | | | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 22, 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD | | | | |
| 10. CITY OR TOWN OF DEATH Ferndale | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 203 Hollins Ferry Road | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter | | | 12b. KIND OF BUSINESS OR INDUSTRY Self-Employed | |
| 13a. STATE Maryland | | 13b. COUNTY AA | | 13c. CITY OR TOWN Jessup | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Clark Road | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John B. Hopkins | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Bentz | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Ferndale, Glen B. Mildren Sturm, 203 Hollins Ferry Rd. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Melanoma</u> 1729 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>NA</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 1971</u> , 19 <u>71</u> , to <u>Jan 23</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>Jan 23</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>E. Roderick Shipley</u> | | | | | DEGREE <u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>Jan 26, 1981</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. E. Roderick Shipley | | | | | 22e. ADDRESS 529 S. Camp Meade Road, Linthicum, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Jan. 26, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Friendship Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Linthicum AA MD | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, MD | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 26 1981 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 1 0 0 1 6 9 E.S.T. | |
|---|--|--|--|---|--|---|---|---|---|-------------------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) EDWARD MELVIN HUTTON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 7, 1981 | | | 2b. HOUR A. M. 6:26 | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 9 23 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Warehouseman | | 12b. KIND OF BUSINESS OR INDUSTRY Pharmaceutical | | | |
| 13a. STATE Md. | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Pasadena | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Winding Woods Way 21122 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Hutton | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Katherine Eckhardt | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) Yes WW 2 | | 16b. SOCIAL SECURITY NO. 212-10-4315 | | 17. INFORMANT ADDRESS Gloria M. Foster same as 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) gram negative septicemia 2765 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dehydration, Hypotension DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Renal Syndrome | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-5-81 to 1-7-81 , that (I) (we) <input checked="" type="checkbox"/> saw the deceased alive on 1-7-81 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | | | DEGREE | | 22c. DATE SIGNED 1/7/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DALJIT S. SAWHNEY, M.D. | | | | | | 22e. ADDRESS 205 BALTIMORE-ANNAPOLIS BOULEVARD GLEN BURNIE, MARYLAND 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/9/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie Anne Arundel Md. | | | |
| 24. FUNERAL DIRECTOR NAME Mc Cully F.H. Mountain & Tick Neck Rds. 21122 | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

MEDICAL CERTIFICATION



DAVID S. SMITH, M.D.
JULY 1951

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(M)

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 0 1 7 0

REG. NO.

| | | | | | | |
|--|--|---|---|--|-----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVA MAE JAHNIGEN | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 09, 1981 | | 2b. HOUR 8:00 A.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 6, 1894 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 10. CITIZEN OF WHAT COUNTRY? USA | | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 12. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | | | |
| 13. CITY OR TOWN OF DEATH GLEN BURNIE | | | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | | |
| 17. 13b. COUNTY Baltimore | | | 18. 13c. CITY OR TOWN Baltimore | | | |
| 19. 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20. 13e. STREET ADDRESS 37 W. Randall St. Balto. Md. | | | |
| 21. FATHER'S NAME FIRST MIDDLE LAST Frank Snyder | | | 22. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Baynon | | | |
| 23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 24. SOCIAL SECURITY NO. 214-01-9462 | | | |
| 25. INFORMANT Mrs. Irma Wroten, 1609 Clarkson St. Balto. Md. | | | 26. ADDRESS | | | |
| 27. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, larynx</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | |
| 28. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | |
| 29a. DATE OF OPERATION | | 29b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 29c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 29d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19 | | | | |
| 31a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 31b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 31c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 31d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| 32. I certify that (I) (this hospital) attended the deceased from <u>June 27</u> 19 <u>65</u> , to <u>Jan. 9</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>March 23</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 33. SIGNATURE <u>Ricardo Lozada</u> | | | | 34. DATE SIGNED 1/10/81 | | |
| 35. PHYSICIAN'S NAME (TYPE OR PRINT) RICARDO LOZADA, M.D. | | | | 36. ADDRESS 1228 SOUTH CHARLES STREET BALTIMORE, MARYLAND, 21230 | | |
| 37. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 38. DATE Jan. 12, 1981 | | 39. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park | | |
| 40. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A. Co. Maryland | | 41. FUNERAL DIRECTOR NAME McCurly Funeral Home, 130 E. Fort Ave. Balto. Md. | | | | |
| 42. DATE RECD. BY REGISTRAR JAN 12 1981 | | 43. HEALTH OFFICER'S SIGNATURE <u>[Signature]</u> | | | | |

RECEIVED 10:00 AM



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8100171 | |
|--|--|---|----------------------|---|--|--|----------|---|-----|---|------|
| 1. FOR STATE REGISTRAR | | | CERTIFICATE OF DEATH | | | | REG. NO. | | EST | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | 2a. DATE OF DEATH | | MONTH | | DAY | YEAR |
| ALICE ADELIA JARRELL | | | | | | JANUARY 31, 1981 | | 9:56 | | P | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | Caucasian | | Oct. 9, 1916 | | 64 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Virginia | | USA | | | | ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | | | Housewife | | Own Home | | | |
| 13a. STATE | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Md. | | | | | | AA | | Glen Burnie | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | | | | |
| N/A | | | | | | N/A | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | | | 579-07-4122 | | George H. Jarrell, Husband, same as 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Pulmonary</u> 5184 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } (b) <u>Post hypoxic encephalopathy</u> gave rise to immediate } DUE TO, OR AS A CONSEQUENCE OF cause (a), stating the } (c) <u>Acute Pulmonary Edema</u> underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Hx of Myocardial Infarction</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-26</u> , 19 <u>81</u> , to <u>1-31</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>1-31</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | 22b. SIGNATURE <u>Edward Sherman</u> DEGREE | | | | 22c. DATE SIGNED <u>2-1-81</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| Edward Sherman | | | | 205 Baltimore-Annapolis Blvd. Glen Burnie, Maryland 21061 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 4 Feb. 81 | | Meadowridge Mem. Pk. Elkridge, Howard Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| James S. Kirkley, Glen Burnie | | | | FEB 2 1981 | | | | <u>[Signature]</u> | | | |

James E. Kirkley, Vice President
4 Sp. St. Bldg.

James E. Kirkley, Vice President

4 Sp. St. Bldg.

James E. Kirkley, Vice President

4 Sp. St. Bldg.

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James E. Kirkley, Vice President

4 Sp. St. Bldg.

James E. Kirkley, Vice President

4 Sp. St. Bldg.

James E. Kirkley, Vice President



5

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 1 0 0 1 7 2

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) <i>Robert Lee Johnson</i> | | | 2a DATE OF DEATH MONTH DAY YEAR <i>1/20/81</i> | | | 2b HOUR <i>9:55 AM</i> | | | |
| 3 SEX <i>male</i> | | 4 RACE <i>white</i> | | 5 DATE OF BIRTH MONTH DAY YEAR <i>10 4 87</i> | | 6 AGE (IN YEARS LAST BIRTHDAY) <i>93</i> YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b CITIZEN OF WHAT COUNTRY? <i>yes - USA</i> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County MD.</i> | | | |
| 10 CITY OR TOWN OF DEATH <i>Brooklyn Park</i> | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hammonds Lane Nursing Center</i> | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Contractor</i> | | 12b KIND OF BUSINESS OR INDUSTRY <i>Building</i> | |
| 13a STATE <i>MD</i> | | | 13b COUNTY <i>Anne Arundel</i> | | 13c CITY OR TOWN <i>Pasadena</i> | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST <i>Johnson H. Johnson</i> | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Adeline Johnson</i> | | | 13e STREET ADDRESS <i>105 Arundel Dr, Pasadena, Md.</i> | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>---</i> | | 17 INFORMANT ADDRESS <i>Mrs. Mildred Johnson Same as #13</i> | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ASCVD CHF</i> <i>4292</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of prostate</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>CVA</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Generalized arteriosclerosis</i> | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>Aug</i> 19 <i>80</i> to <i>Jan 16</i> 19 <i>81</i> , that (I) (we) lost saw the deceased alive on <i>Jan 16</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE <i>Mustafa C. Oz</i> | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED <i>Jan 20 81</i> | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Mustafa C. Oz</i> | | | | | 22e ADDRESS <i>605 B-A Blvd Severna park Md</i> | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | 23b DATE <i>1/23/1981</i> | | 23c NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem. Park</i> | | 23d LOCATION CITY OR TOWN COUNTY STATE <i>Glen Burnie Anne Arundel Md</i> | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS <i>McCully F.H. Mtn. & Tick Neck Rds., Pasadena, Md.</i> | | | | | 25a DATE REC'D. BY REGISTRAR <i>Jan 27 1981</i> | | 25b REGISTRAR'S SIGNATURE <i>Robert Johnson</i> | | |

35 90 35 22 1

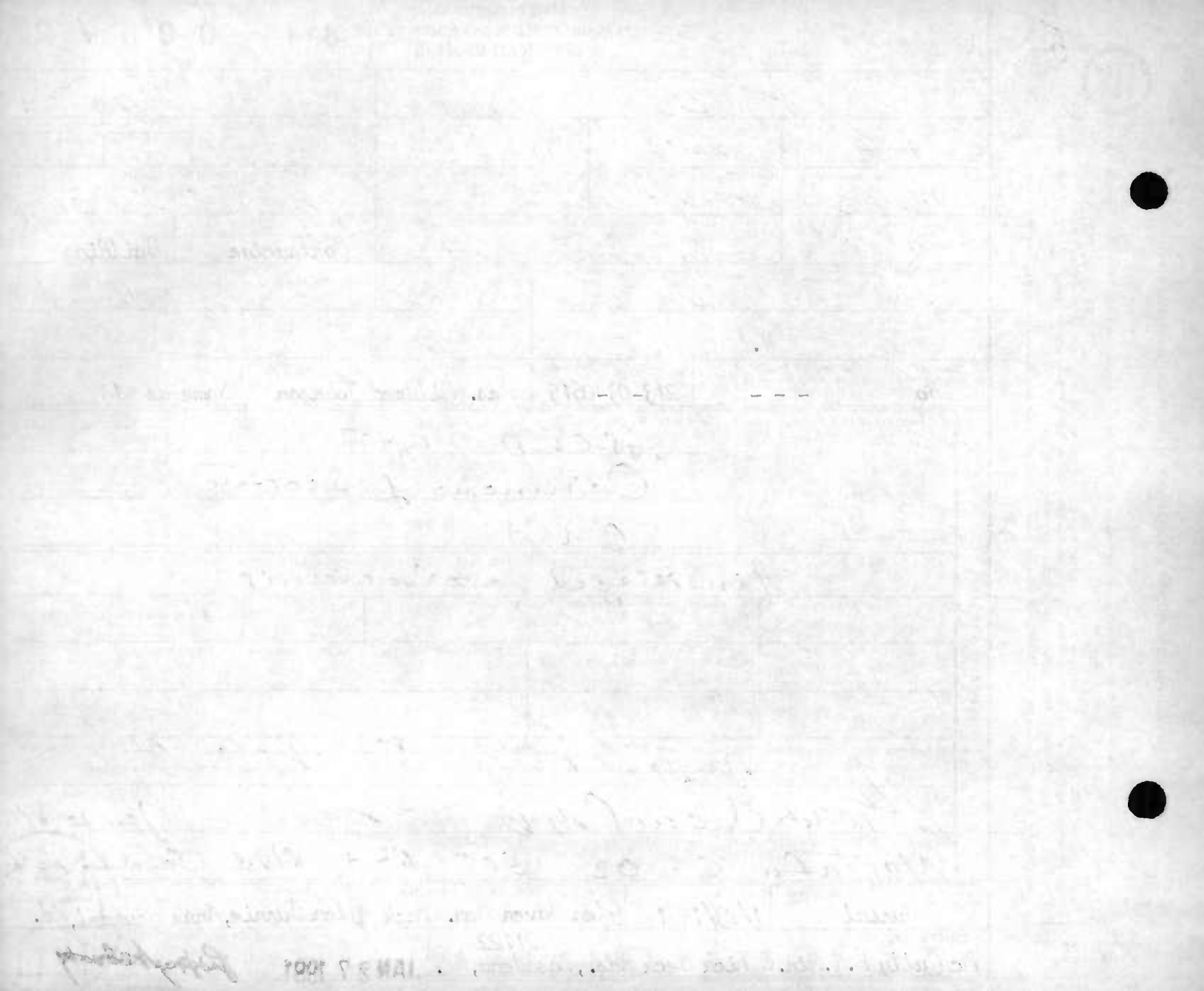
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

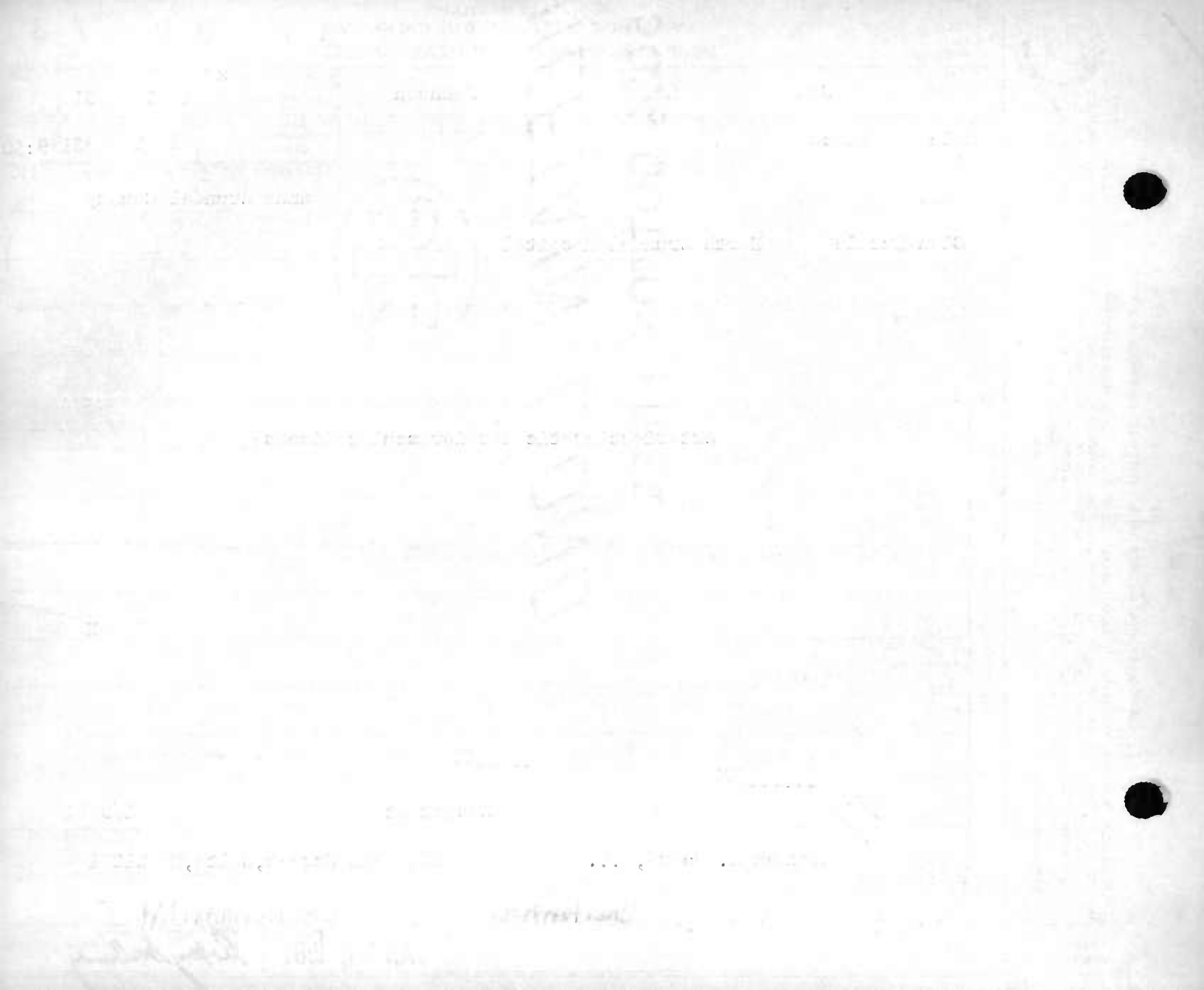


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17
(VR A15 ME (5))
15M 2/80

| FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 00173 | | | | | | | | | |
|--|--|----------------------|--|---------------------------------------|--|----------------------------------|--|--|--|---|--|---|--|--|--|--|--|--|--|--|--|----------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Sam L Johnson | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 1 DAY 2 YEAR 1981 | | | | | | | | | | 2b. HOUR 9:50 | | | | | | | | | | | | | | | | | | | |
| 3. SEX male | | 4. RACE black | | 5. DATE OF BIRTH April 6, 1936 | | 6. AGE (IN YEARS) 44 YRS. | | IF UNDER 1 YR. MONTHS 0 DAYS 0 | | IF UNDER 24 HRS. HOURS 0 MIN. 0 | | 2c. DATE PRONOUNCED DEAD 1 2 19 81 | | | | | | | | | | 2d. HOUR 9:50 | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) student | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY ----- | | | | | | | | | |
| 13a. STATE Md. | | | | | | | | | | 13b. COUNTY A.A. Co. | | | | | | | | | | 13c. CITY OR TOWN Gambrills, | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 1017 April Ct. | | | | | | | | | |
| 14. FATHER'S NAME Sam Levy Johnson Sr. | | | | | | | | | | 15. MOTHER'S MAIDEN NAME Beatrice Pendergast | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | | | | | | | | | 16b. SOCIAL SECURITY NO. 56-76 579-48-5567 | | | | | | | | | | 17. INFORMANT Judith Irene Johnson ADDRESS same as 13e. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE H. Guard | | | | | | | | | | TITLE (SPECIFY) Assistant | | | | | | | | | | DATE SIGNED 1/3/81 | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. | | | | | | | | | | ADDRESS 111 Penn Street, Balto, MD 21201 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | | | | | 23b. DATE 1/6/81 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Cheltenham VA Cem | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham MD | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Hardesty Funeral Home | | | | | | | | | | ADDRESS 12 Ridgely AV Ann. Md. 21401 | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 6 1981 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8100174 | |
|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | |
| MARTHA L. JONES | | | | JANUARY 15, 1981 | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 7, 1908 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oklahoma | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | 13a. STREET ADDRESS 8355 Old Annapolis Rd. | |
| 13a. STATE MD. | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Pasadena | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Welburn | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | |
| 16b. SOCIAL SECURITY NO. 456-10-2413 | | 17. INFORMANT Alfred P. Jones - Sec 13 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u> 4920 DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>emphysema, pulm.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>depression, TIA</u> | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/1/81</u> to <u>1/15/81</u> , that (I) (we) lost saw the deceased alive on <u>1/12/81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) James T. Benjamin | | | | 22c. DATE SIGNED 1/15/81 | |
| 22d. ADDRESS 7300 RITCHIE HIGHWAY GLEN BURNIE, MARYLAND 21061 | | | | 22e. ADDRESS 7300 RITCHIE HIGHWAY GLEN BURNIE, MARYLAND 21061 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 1-17-81 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Crematory | |
| 24. FUNERAL DIRECTOR NAME Robert S. Barranco | | ADDRESS Severna Park | | 25a. DATE RECEIVED BY REGISTRAR JAN 15 1981 | |

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE

NEW YORK

UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE

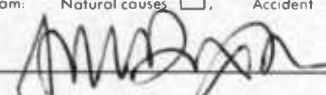

UNITED STATES DEPARTMENT OF JUSTICE



UNITED STATES DEPARTMENT OF JUSTICE

Items #15a-22a Film G522 2/17/81 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 00175

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) HELEN (nmn) JURIMA | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 17 19 81 | | | | 2b. HOUR M | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 1, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tallin, Estonia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD. | | | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital (DOA) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY Dept. Store | |
| 13a. STATE Maryland | | | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Pasadena | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN Siikov | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | |
| 17. INFORMANT (Daughter) Mrs. Imbi M. Ross | | | | 18. ADDRESS 2049 Hermitage Hills Dr. Gambrills, Md. | | | | 19. SOCIAL SECURITY NO. 214.30.5958 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute drug intoxication involving propoxyphene 9500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1/17/81 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Ingested overdose | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 656 Laurel Dr. Pasadena A.A. Co., Md. | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 1-19-81 | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Bixon, M.D. | | | | ADDRESS 111 Penn St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 22 JAN. 81 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A., Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Singleton Funeral Home Md. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 22 1981 | | 25b. REGISTRAR'S SIGNATURE  | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 00176

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Caroline Emma Kaline | | 2a. DATE OF DEATH MONTH DAY YEAR 1 22 81 | | 2b. HOUR 9 ⁰⁰ AM | |
| 3. SEX Fe | 4. RACE Cauc | 5. DATE OF BIRTH MONTH DAY YEAR 10 25 00 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 80 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE Md | 13b. COUNTY AACo | 13c. CITY OR TOWN Annapolis | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 103 Hearne Rd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Rudolph Dolle | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Hyle | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | 16b. SOCIAL SECURITY NO. 213 30 9736 | | 17. INFORMANT ADDRESS Margaret Kroeger, Davidsonville, Md 21035 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 ASCVD DUE TO, OR AS A CONSEQUENCE OF (b) arterial embolus DUE TO, OR AS A CONSEQUENCE OF (c) A/O osteomyelitis Polythemia | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/22/81, 19____, to 1/22/81, 19____, that (I) (we) lost saw the deceased alive on 1/21/81, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Stanley Watkins | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/22/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY WATKINS | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-24-81 | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md |
| 24. FUNERAL DIRECTOR NAME Hardesty FH, 12 Ridgely Ave, Annapolis, Md. 21401 | | 25a. DATE REC'D. BY REGISTRAR JAN 26 1981 | | 25b. REGISTRAR'S SIGNATURE D. J. H. H. H. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



PAID

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[Handwritten signature]

JAN 2 1961

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

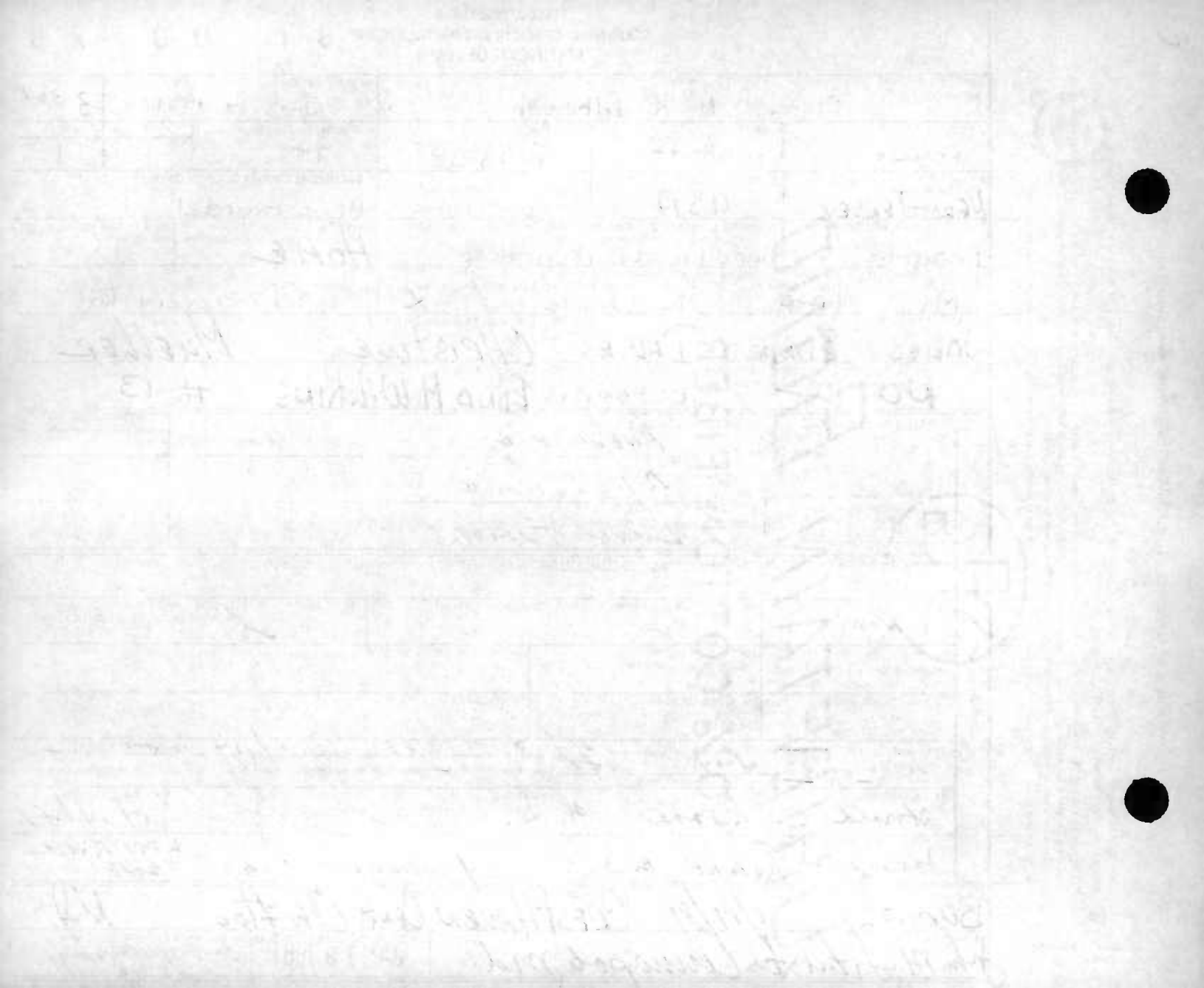
FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | |
|---|--|---|--------|---|---|---|--|---|---|--|--|---------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | | | |
| WILLIAM C. KIMBROW | | | | | 1 17 81 | | | | | 9:20 A.M. | | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| MALE | | NEGRO | | Sept. 12 1912 | | 68 | | MONTHS DAYS | | HOURS MIN | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| TENNESSE | | U.S.A. | | | | ANNE ARUNDEL COUNTY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| ANNAPOLIS | | 192 Clay Street | | | | | | | | | | | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | |
| MARYLAND | | | | | A.A. | | ANNAPOLIS | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 192 Clay Street | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| FIRST MIDDLE LAST CALVIN KIMBROW | | | | | FIRST MIDDLE LAST BLANCHE KIMBROW | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | | |
| NO | | | | | 403-10-4338 | | CARRIE KIMBROW 192 Clay St. Annapolis, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC LYMPHATIC LEUKEMIA | | | | | | | | | | 5 Years | | | |
| 2041 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Charles W. Kinzer | | | | | | DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-17-1981 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES W. KINZER | | | | | | 22e. ADDRESS 17 Murray Ave. Annapolis, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| BURIAL | | | | 1-21-1981 | | CEDAR HILL CEMETERY | | Brooklyn Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A. | | | | | | ADDRESS Annapolis, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 26 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 81 00179 | | | |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 21 81 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HUGO E KNIGHT | | | | 2b. HOUR 02:20 P.M. | | | |
| 2. SEX Male | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR AUG. 24 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSP | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCK DRIVER | | 12b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED | |
| 13a. STATE MD | | 13b. COUNTY AA | | 13c. CITY OR TOWN LAUREL | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS 3567 FT. MEADE RD | | 14. FATHER'S NAME FIRST MIDDLE LAST DENNIS KNIGHT | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PEARL | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 216243340 | | 17. INFORMANT BERTHA HOOD | | ADDRESS ABOVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal carcinoma 1991 DUE TO, OR AS A CONSEQUENCE OF metastatic carcinoma (b) primary unknown DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 20 19 80 to Jan 16 19 81, that (I) (we) last saw the deceased alive on Jan 16 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Kuang-yen Huang M.D. | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 01/22/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KUANG-YEN HUANG | | 22e. ADDRESS BON Secours Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JAN 23 1981 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BROOKLYN PARK MD | |
| 24. FUNERAL DIRECTOR | | 25. DATE REC'D. BY REGISTRAR | | 25a. REGISTRAR'S SIGNATURE | | | |

REPORT
OF THE
COMMISSIONERS OF THE
LAND OFFICE
IN RESPONSE TO A
RESOLUTION PASSED BY THE SENATE
JANUARY 18, 1880.
ALBANY:
J. B. LEECH, PRINTER.
1881.

1881

JAN 20 1881

1881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 0 1 B.S.O.
REG. NO.

| | | | | | | | |
|---|--|--|---|---|--------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM A. KOHLHOFF | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 9, 1981 | | 2b. HOUR A M 6:30 | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 13, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fireman | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Louis | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise | | 16. ADDRESS 477 E. Font Ave. Balto. Md. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 215-30-4312 | | 17. INFORMANT Mr. William A. Kohlhoff, 3rd. Same as above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4920 DUE TO, OR AS A CONSEQUENCE OF (b) COPD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) rescued | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 113 , 19 81 , to 119 , 19 81 , that (I) (we) last saw the deceased alive on 118 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Robert B. Kroopnick | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/9/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT B. KROOPNICK, M.D. | | 22e. ADDRESS 205 BALTIMORE-ANNAPOLIS BOULEVARD GLEN BURNIE, MARYLAND 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment | | 23b. DATE Jan. 12, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME McCully Funeral Home, 130 E. Font Ave. Balto. Md. | | 25a. DATE REGD. BY REGISTRAR JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE Robert B. Kroopnick | | | |



65-11-101100-204

11/10/54

ROBERT D. WOODRUFF, M.D.

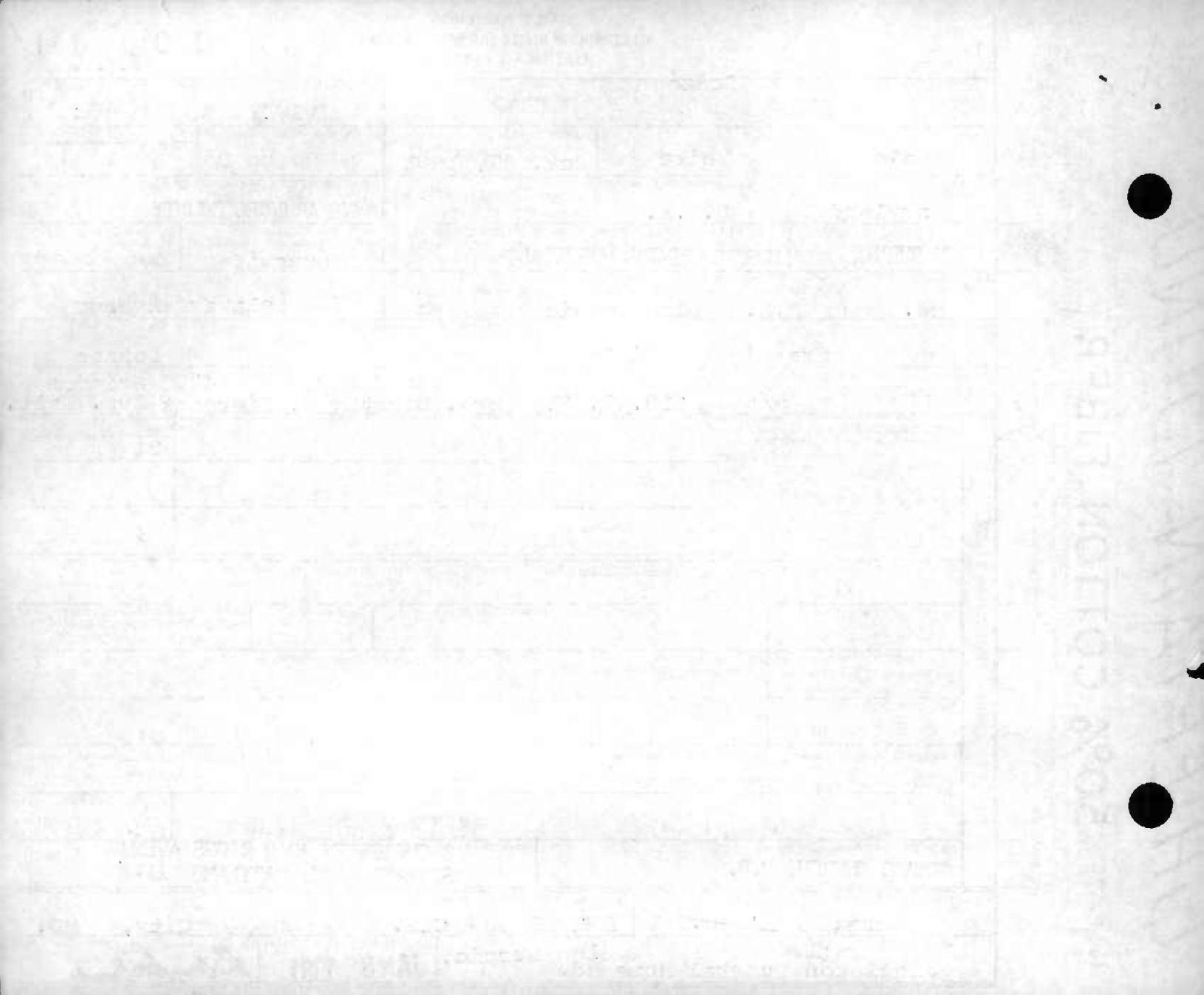
DR. ROBERT D. WOODRUFF, M.D.
1000 K STREET, N.W.
WASHINGTON, D.C. 20001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
|--|--|--|--|--|---|--|---|---|---|---|--|--|-----------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | 8 1 0 0 1 8 1 REG. NO. E.S.T. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST Doxxen LAST KORBACH MARION D. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 4, 1981 | | | | | 2b. HOUR P M 11:20 P M | | | | |
| 3. SEX Female | | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 27, 1901 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY own home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 504 Delaware Avenue | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Francis Bigley | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie Doxxen | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT (Daughter) Mrs. Dorothy M. Pierpont Ave., Balt. | | | ADDRESS 4706 Grindon | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Left ventricle failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Emergency deseri APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours Yes Yes | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypertension | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 1/4/81 | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 76 1/4/81 81 | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/4/81 19 81 , to 1/4/81 19 81 , that (I) (we) last saw the deceased alive on 1/4/81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE Gerard Church | | | | | DEGREE | | | | | 22c. DATE SIGNED 1/4/81 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GERARD CHURCH, M.D. | | | | | 22e. ADDRESS 8 EVERGREEN ROAD RIGGS AVENUE SEVERNA PARK, MARYLAND 21146 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | 23b. DATE 7 JAN. 81 | | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEM. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City MD. | | | | |
| 24. FUNERAL DIRECTOR NAME S. Thibault ADDRESS Glen Burnie, Md. | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1981 | | | | | 25b. REGISTRAR'S SIGNATURE Richard H. ... | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the Registrar, State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 1 0 0 1 8 2 | |
|---|--|--|--|---|--|---|--|---|--------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) STEPHEN KUROWSKI | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 10, 1981 | | | 2b. HOUR EST 10:27 A | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 6 27 05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Erector | | 12b. KIND OF BUSINESS OR INDUSTRY Steel Mfg. | | | |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Pasadena | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Apple Tree Dr. Bayside Beach | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST unknown | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 131-07-0944 | | 17. INFORMANT ADDRESS Nora Lee Eby - same as 13 above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4281 DUE TO, OR AS A CONSEQUENCE OF (b) Acute tubular necrosis DUE TO, OR AS A CONSEQUENCE OF (c) Complete A-V block Acute (2) ventricular failure | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hx of hypertension; CRBBB & LAH; COPD | | | | | | | | | | | |
| 19a. DATE OF OPERATION 1/9/81 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Complete A-V block, Temp. permanent | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER IN ITEM 18, PART I OR PART 2) N/A. | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 8 1981 to Jan. 10 1981 that (I) (we) last saw the deceased alive on Jan. 10 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Benjamin A. de Guzman, M.D. | | | | | | DEGREE M.D. | | 22c. DATE SIGNED 1/10/81 | | 22d. MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) BENJAMIN A. de GUZMAN, M.D. | | | | | | 22f. ADDRESS 325 HOSPITAL DRIVE, #108 GLEN BURNIE, MARYLAND 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/13/81 | | 23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Marion Somerset Md. | | | |
| 24. FUNERAL DIRECTOR NAME Bradshaw & Sons | | | | | | ADDRESS Crisfield, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 20 1981 | | 25b. REGISTRAR'S SIGNATURE P. J. [Signature] | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8100183

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elois M Lambrose | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 4 81 | | 2b. HOUR 9:55 P.M. |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR 4 22 13 | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | |
| 10. CITY OR TOWN OF DEATH Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse | 12b. KIND OF BUSINESS OR INDUSTRY Health | |
| 13a. STATE MD. | | | 13b. COUNTY A.A. | 13c. CITY OR TOWN Mayo | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Wallace Thompson | | | 15. MOTHER'S MARRIED NAME MIDDLE LAST Collison | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-30-0887 | 17. INFORMANT Address Patricia A Flynn 1912 County Rd. District Heights Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac-pulmonary arrest 4149 DUE TO, OR AS A CONSEQUENCE OF: (b) Ventricular fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF: (c) Severe coronary artery disease | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Ventricular aneurysm cardiomegaly CHF | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 22 to 1/4 19 81, that (I) (we) lost saw the deceased alive on 1/4 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE Joseph N. Friend for George Sawner | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/5/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph N. Friend | | 22e. ADDRESS 1616 Forest Dr. Annapolis, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1/7/81 | 23c. NAME OF CEMETERY OR CREMATORY Mayo Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Mayo A.A. MD. | |
| 24. FUNERAL DIRECTOR NAME John M. Taylor & Sons | | ADDRESS Annapolis, MD. | | 25a. DATE REC'D. BY REGISTRAR JAN 12 1981 | 25b. REGISTRAR'S SIGNATURE [Signature] |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 5, 6, 8, 553 3/18/81 g3

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 00184

| | | | | | |
|--|--|---|--|--|---|
| FOR 1- STATE REGISTRAR | | REG. NO. | | EST | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | LAST | |
| MARTIN | | R. | | LANE | |
| 3 SEX MALE | | 4 RACE NEGRO | | 5. DATE OF BIRTH MONTH DAY YEAR 2 1900 1908 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 72 80 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10 CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| 13a STATE MARYLAND | | 13b COUNTY A.A. | | 13c CITY OR TOWN ANNAPOLIS | |
| 14 FATHER'S NAME FIRST MIDDLE LAST LOUIS LANE | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA LANE | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-12-3879 | | 17 INFORMANT ADDRESS TOMMY THOMAS 34 Lafayette Ave. Annapolis, Md. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right lower lobe pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>pneumothorax</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aneurysm - GI Bleed</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>12/22</u> 19 <u>80</u> to <u>1/13</u> 19 <u>81</u> , that (I) <u>first</u> last saw the deceased alive on <u>1/13/81</u> 19 <u>81</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE <u>E. Arundel MD</u> | | DEGREE | | 22c DATE SIGNED <u>1/13/81</u> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Loor baty</u> | | 22e ADDRESS <u>North Arundel Hosp</u> | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b DATE 1-19-1981 | | 23c NAME OF CEMETERY OR CREMATORY HILL CREST MEM. PARK | |
| 23d LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland | | 24 FUNERAL DIRECTOR WILLIAM REESE & SONS MORTUARY, P.A. | | 25a DATE REC'D. BY REGISTRAR JAN 16 1981 | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 00185 | |
|---|-------------------------|---|---|---|--|--|--|--|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Thomas E. Lane, Jr. | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1 27 81 | | 2b. HOUR AM | | | |
| 1. SEX male | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR 10 25 37 | 6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 27 81 | | 2d. HOUR 10 34 PM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pharmacist | | 12b. KIND OF BUSINESS OR INDUSTRY Lawson & Sons Pharmacy | | | |
| 13a. STATE Maryland | | 13b. COUNTY A.A. Co. | | 13c. CITY OR TOWN Linthicum, Md. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas E. Lane, Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alta E. Seligman | | 16. SOCIAL SECURITY NO. 218-34-9964 | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. 218-34-9964 | | 17. INFORMANT ADDRESS Linthicum, Md. Marian F. Lane 458 Kingswood Road 21090 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9504 IMMEDIATE CAUSE (a) Digoxin intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR Est. 1/26/81 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self induced | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) unknown | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE unknown | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: No Arterial Causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE H Guard | | TITLE (SPECIFY) Assistant | | M.D. _____ | | MEDICAL EXAMINER | | DATE SIGNED 1/28/81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. | | ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/31/81 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Baltimore, Md. 21229 4107 Wilkems Ave. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 30 1981 | | 25b. REGISTRAR'S SIGNATURE Robert McCreedy | | | | | |

SECRET

1. The first part of the document is a list of names and titles of the members of the committee. The names are listed in alphabetical order. The titles are listed in the order in which they appear in the document.

2. The second part of the document is a list of the names of the members of the committee who have been assigned to the various subcommittees. The names are listed in alphabetical order. The subcommittees are listed in the order in which they appear in the document.

3. The third part of the document is a list of the names of the members of the committee who have been assigned to the various subcommittees. The names are listed in alphabetical order. The subcommittees are listed in the order in which they appear in the document.

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10. The tenth part of the document is a list of the names of the members of the committee who have been assigned to the various subcommittees. The names are listed in alphabetical order. The subcommittees are listed in the order in which they appear in the document.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8100186 | | | |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST EMMA V. VIOLA LEGG | | | | January (1) 28 / 81 4:20 A.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH July 8, 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Maryland | | | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Annapolis | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Clendening Pippin | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Lane | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214-74-3282 | | 17. INFORMANT Daughter ADDRESS 108 Edelmars Drive Mrs. Frances L. Wilmer, Annapolis, Md. 21403 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest. 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis. 7 days Long standing | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from July 1975, to Jan 28, 1981, that (I) (we) last saw the deceased alive on Jan 27, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Rodney L. Brimhall MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED Jan. 28, 1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rodney L. Brimhall, M.D. | | | | 22e. ADDRESS Annapolis, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 30, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Chesterfield | | 23d. LOCATION CITY OR TOWN COUNTY STATE Centreville, Q.A.Co., Md. | |
| 24. FUNERAL DIRECTOR Barton Bros. James H. Barton, Jr., Centreville, Md. 21617 | | | | 25a. DATE RECEIVED BY REGISTRAR FEB 3 1981 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

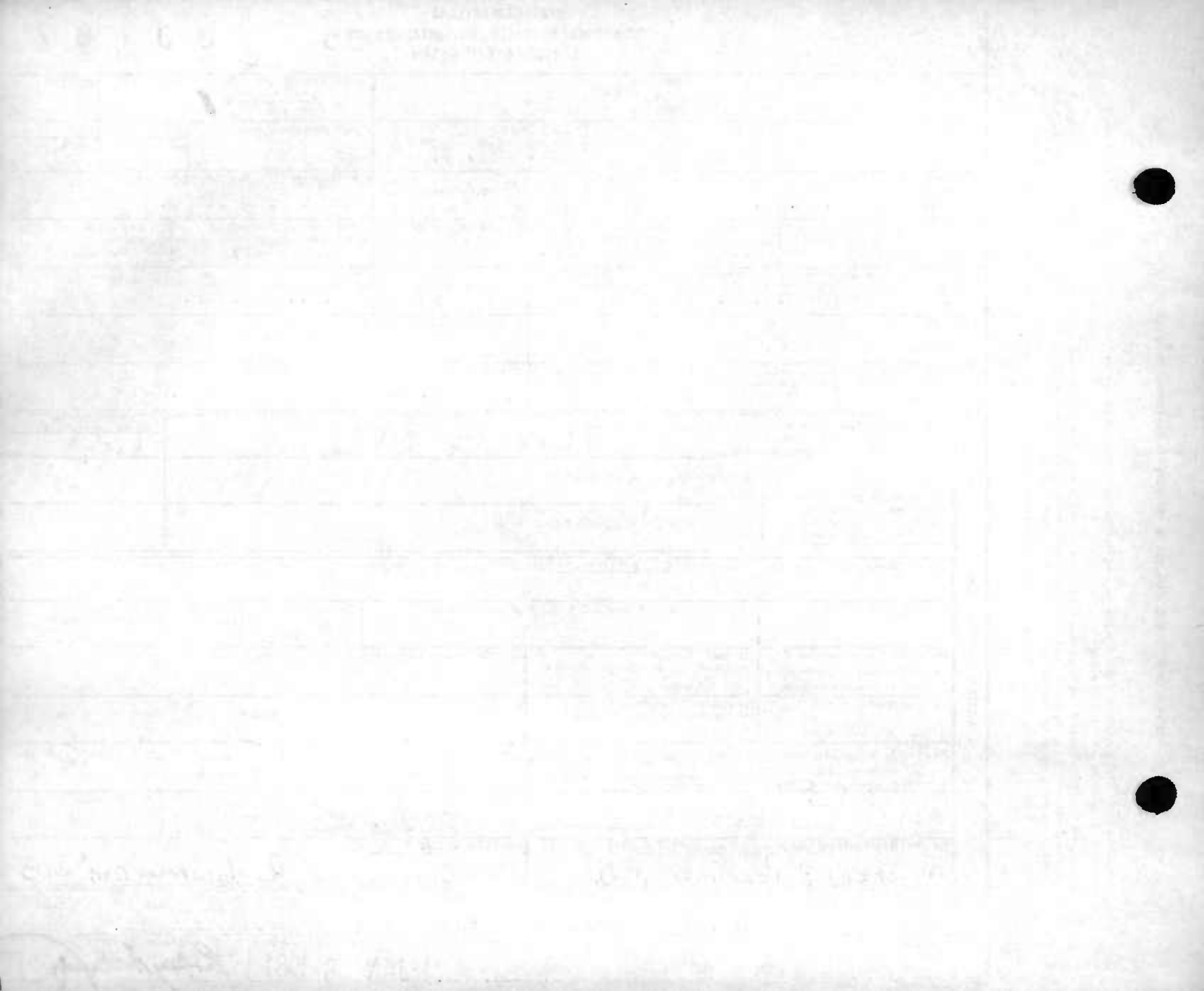
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8100187

| | | | |
|--|------------------|---|--|
| FOR 1- STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Ethel Ruth Lohrman | | 2a. DATE OF DEATH MONTH DAY YEAR 1-4-1981 | |
| 3. SEX female | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 27, 1917 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 63 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lincoln Co. W. Va. | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD. | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hosp. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY US Gov't | |
| 13a. STATE Md. | | 13b. CITY OR TOWN A. A. Co. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Rome E. Vickers | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Watts | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 235-16-6476 | |
| 17. INFORMANT ADDRESS James F. Lohrman same as 13e. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>NTS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (11a) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-3-80</u> to <u>1-4-81</u> , that (I) (we) last saw the deceased alive on <u>12-15-80</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (we) did not see the body after death. | | 22b. SIGNATURE DEGREE <u>[Signature]</u> | |
| 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael B. Pearlman M.D. | |
| 22e. ADDRESS 5400 Old Court Rd, Randallstown Md. 21133 | | 22f. ATTENDING PHYSICIAN MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/7/81 | |
| 23c. NAME OF CEMETERY OR CREMATORY Crownsville VA Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, Md. | |
| 24. FUNERAL DIRECTOR NAME Hardesty Funeral Home | | 25a. DATE REC'D. BY REGISTRAR JAN 6 1981 | |
| 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |



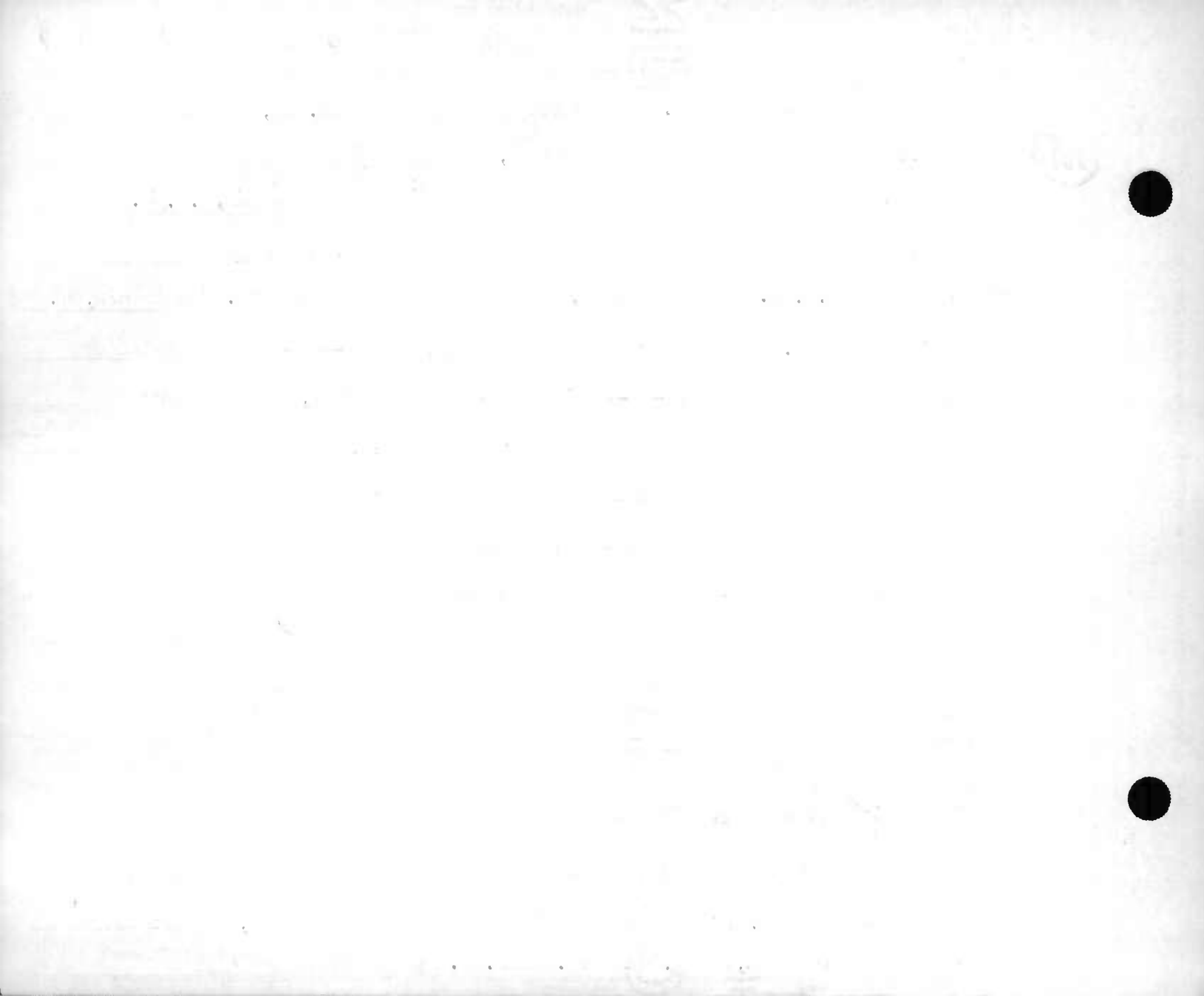
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

| | | | | | | | | | |
|---|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Charles W. Long</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>Jan. 29, 1981</i> | | | 2b. HOUR M <i></i> | | | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>March 17, 1908</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>72</i> | | IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Glen Burnie, A.A.Co.</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH <i>Glen Burnie</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>North Arundel Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Warehouseman</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>A.A.Co.</i> | | 13c. CITY OR TOWN <i>Glen Burnie,</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS <i>319 Wende Ct. Glen Burnie, Md.</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>John D. Long</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna Ricketts</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>219-01-7432</i> | | 17. INFORMANT ADDRESS <i>Catherine Monnessey, Same as above</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute respiratory arrest.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Severe Pulmonary Obstructive</i> DUE TO, OR AS A CONSEQUENCE OF Disease (c) <i>Pulmonary Interstitial Fibrosis</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>For Pulmonale, Arteriosclerotic Vascular Disease</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>July 17, 1972</i> to <i>January 29, 1981</i> , that (I) (we) last saw the deceased alive on <i>January 29, 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Consolador O. Palad, Jr.</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <i>1/30/81</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Consolador O. Palad, Jr., M.D.</i> | | | | 22e. ADDRESS <i>909 Light Street, Baltimore, Md. 21230</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>Feb. 2, 1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i> | | | |
| 24. FUNERAL DIRECTOR NAME <i>McGully Funeral Home, 130 E. Fort Ave. Balto. Md.</i> | | | | 25. DATE REC'D. BY REGISTRAR <i>FEB 3 1981</i> | | 25. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |





5

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 0 1 8 9

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>John Edward Lurz</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>1 25 81</i> | | | 2b. HOUR <i>11:30 A M</i> | | | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>11 19 81</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>93</i> YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH <i>Brooklyn Park</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hammonds Lane Nursing Center</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Boat Builder</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Boating</i> | |
| 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>Anne Arundel</i> | | 13c. CITY OR TOWN <i>Pasadena</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS <i>273 Gibson Rd.</i> <i>21122</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>John Lurz</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sophie Mattausch</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | | |
| 16b. SOCIAL SECURITY NO. <i>214-46-2003</i> | | | 17. INFORMANT ADDRESS <i>C. Wilmer Lurz 172 Second St., Pasadena, Md.</i> | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pneumonia</i> 4379 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c): <i>Cardiac decompensation</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July 31 19 75</i> to <i>January 25 19 81</i> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <i>January 25 19 81</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Lorraine M. Dailey</i> | | | DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED <i>1-26-81</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lorraine M. Dailey, M.D.</i> | | | 22e. ADDRESS <i>8667 Ft Smallwood Rd Pasadena, Md. 21122</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | 23b. DATE <i>1/28/1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Most Holy Redeemer Cem.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Md.</i> | | |
| 24. FUNERAL DIRECTOR NAME <i>Mc Cully F.H. Mtn. & Tick Neck Rds., Pasadena, Md.</i> | | | ADDRESS <i>21122</i> | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 27 1981</i> | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | |

The medical examiner must be notified of a death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a death.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 00190

1- FOR
STATE REGISTRAR *Luther*

REG. NO.

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Luther</i> FIRST <i>George</i> MIDDLE <i>Edmund</i> LAST <i>Luther</i> | | | 2a. DATE OF DEATH MONTH <i>1</i> DAY <i>6</i> YEAR <i>81</i> | | 2b. HOUR <i>7:15 AM</i> |
| 3. SEX <i>Male</i> | 4. RACE <i>White</i> | 5. DATE OF BIRTH MONTH <i>1</i> DAY <i>11</i> YEAR <i>01</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Annapolis</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel Gen Hosp</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Wire Repeter</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Wester Union</i> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>Md.</i> 13c. COUNTY <i>Q.A. Co.</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS <i>Rt#1 Box # 580</i> | | |
| 14. FATHER'S NAME FIRST <i>George</i> MIDDLE <i>Hays</i> LAST <i>Luther</i> | | | 15. MOTHER'S MAIDEN NAME FIRST <i>Minnie</i> MIDDLE <i>Mae</i> LAST <i>Warner</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i> | | 16b. SOCIAL SECURITY NO. <i>W.W. #1 012-01-3128</i> | | 17. INFORMANT ADDRESS <i>George H. Luther, Rt#1 Box #580 Stevensville, Md.</i> | |

MEDICAL CERTIFICATION

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>intractable congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF: (c) <i>4392</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>11 months</i> <i>4 years</i> |
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
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|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) this hospital attended the deceased from <i>11/5</i> 19 <i>81</i> to <i>1/6</i> 19 <i>81</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>1/5</i> 19 <i>81</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) <i>(we)</i> did (did not) view the body after death. | | | |
| 22b. SIGNATURE <i>Wm A Cassidy</i> | | DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED <i>1/6/81</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wm A Cassidy</i> | | 22e. ADDRESS <i>2510 Riva Rd Annapolis 21401</i> | |

| | | | |
|--|-------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | 23b. DATE <i>1-8-81</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i> | 23d. LOCATION CITY OR TOWN <i>Balt. City</i> COUNTY <i>Md.</i> STATE <i>Md.</i> |
| 24. FUNERAL DIRECTOR NAME <i>Helfenbein-Hubbard Funeral Home</i> ADDRESS <i>Chester, Md. Box 66-B</i> | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 12 1981</i> | 25b. REGISTRAR'S SIGNATURE <i>Barney McLeod</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8100191

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|--|--|----------------------------|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) Arthur A. MacLEAN | | | 2a DATE OF DEATH MONTH DAY YEAR 1-3-81 | | 2b HOUR 12:35 PM | | |
| 3 SEX MALE | | 4 RACE WHITE | | 5 DATE OF BIRTH MONTH DAY YEAR 4 12-95 | | 6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD. | |
| 10 CITY OR TOWN OF DEATH Brooklyn | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hammonds Lane Nursing Home | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tread Molder | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md. | | 13b COUNTY A.A. Co. | | 13c CITY OR TOWN Brooklyn | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Allan MacLean | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christina | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | |
| 16b SOCIAL SECURITY NO. 033 09 6511 | | 17 INFORMANT Bonnie Baxley | | ADDRESS Pasadena 21122 | | | |

| | | | | | |
|--|--|--|--|--|--|
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Renal Insufficiency 5829 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Chronic Obstructive Pulmonary Disease: Senile dementia | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Nicholas Schwartz MD | | | | DEGREE | |
| 22c. DATE SIGNED 1/5/81 | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | |

| | | | | | | | |
|--|--|----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/7/81 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS George J. Gonce 4001 Ritchie Hwy. Balto 21225 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO THE
DIRECTOR
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00192

1- FOR
STATE
REGISTRAR

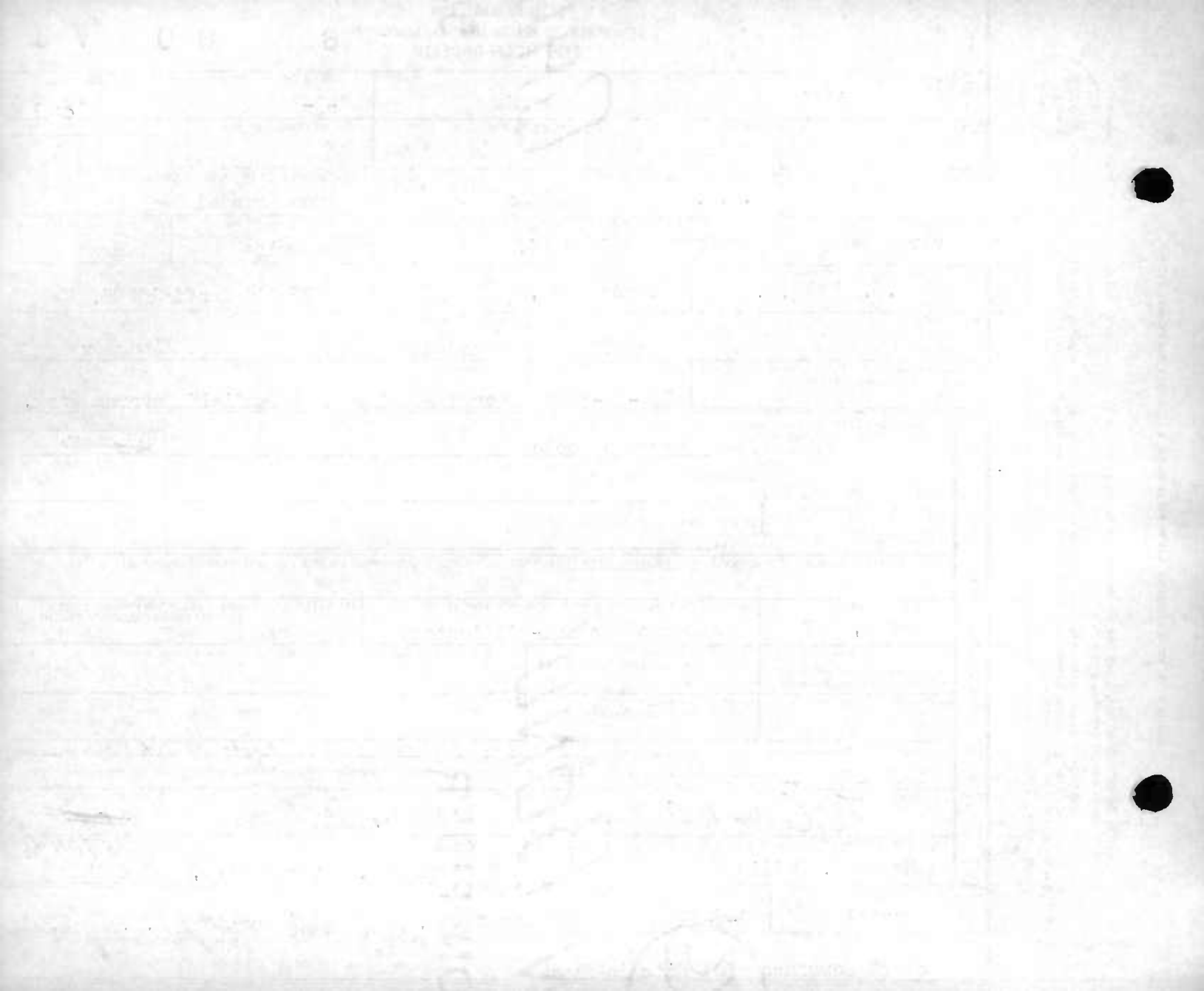
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|--|--|------------------|--|---|--|--|--|---|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Dudley | | MIDDLE T | | LAST MANN | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1 12 1981 | | | | 2b. HOUR P M | | | | | | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 1 1 82 | | 6. AGE (IN YEARS) LAST BIRTHDAY 89 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD 1 12 1981 | | 2d. HOUR P M | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1410 Houghton Drive | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Timekeeper | | | | 12b. KIND OF BUSINESS OR INDUSTRY Am. Can Co. | | | | | | | |
| 13a. STATE Md. | | | | | | | | | | | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1410 Houghton Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Thomas Mann | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Malvina --- Unknown | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 216-05-0952. | | | | 17. INFORMANT Mary Mann XXXXXXXXXXXXXXX Elizabeth Walker | | | | ADDRESS Same as #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm & A/S</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Dinner | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>E. Linhardt</i> | | | | TITLE (SPECIFY) M.D. <i>Depot 9</i> | | | | MEDICAL EXAMINER | | | | DATE SIGNED 1.12.81 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) E. Linhardt | | | | ADDRESS Annapolis, Md. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1/14/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Ritchie Hwy., Balto., Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Mcully Funeral Home | | | | ADDRESS Balto., Md., 21225 237 E. Patapsco Ave., | | | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1981 | | | | 25b. REGISTRAR'S SIGNATURE <i>R. J. Kennedy</i> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8100193 | |
|---|--|--|--|--|--|---|--|-----------------------------|--|---------------------------|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | | | |
| | | Lillian Manning | | | | 1-3-81 | | 6A | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | |
| Female | | White | | Oct 14 1894 | | 86 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | MD. | |
| Maryland | | U.S.A. | | | | Anne Arundel | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Severna Park | | 727 Old Benfield Rd. | | Housewife | | Home | | | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS | | | | | |
| M.D. | | A.A. | | Severna Park, | | 727 Old Benfield Rd. | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | |
| John Powell | | Henrietta Albecker | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | |
| no | | 217-26-5902 | | George Manning 666 Benfield Severna Park, | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of colon</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/4 mo | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| Nov 9, 1979 | | Cancer of colon - illiostomy | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from Oct 19 79, to Jan 3 81, that (I) (we) lost saw the deceased alive on Nov 30 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | |
| Thomas C. Cullis | | | | | | 5 JAN 81 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| Thomas C. Cullis | | 7 Riggs Ave. Severna Park, Md 21146 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 1-6-81 | | Glen Haven Cem. | | Glen Haven A.A. M.D. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 24a. DATE REC'D. BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | | | | |
| Robert Barranco | | 501 Ritchie Hwy | | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

FOR
1- STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 00194

| | | | | | | | | | | | | | | | |
|--|---------|--|--|---|--|---|--|--|--|---------------------------|--|--------------------------------------|--|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | |
| virginia R. MARABLE | | | | | | | | <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 1 19 81 P M | | | | <input type="checkbox"/> 1 19 81 P M | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | | 2d. HOUR | |
| Female | white | 3 28 08 | | 72 YRS. | | | | | | MONTH DAY YEAR 1 19 81 | | | | MONTH DAY YEAR 1 19 81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Maryland | | U.S.A. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Anne Arundel MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Annapolis | | Anne Arundel General. | | Housewife | | Home | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | |
| MD | | A.A. | | Severna Park | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 100 Askeaton Rd. | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 17. ADDRESS | | | | | |
| Unknown | | Reynolds | | No | | 213-50-9120 | | Capt. Herbert H. Marable | | Sec. 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 4029 | | Hypertensive C.V.B. | | | | | | Oudden | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | P.M. 19 | | | | AT WORK <input type="checkbox"/> | | STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | TITLE (SPECIFY) | | DATE SIGNED | | 1-19-81 | | | | | | | |
| ACTUAL SIGNATURE | | E. Linhardt | | M.D. Deputy | | MEDICAL EXAMINER | | ADDRESS | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | E. Linhardt | | ADDRESS | | Annapolis, Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | |
| Cremation | | 1-19-81 | | Westview Crematory | | Westview | | Baltimore | | MD. | | | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Robert J. Barranco | | 501 Ritchie Hwy | | Severna Park MD. | | JAN 23 1981 | | | | | | | | | |

WOMAN'S CHRISTIAN TEMPERANCE UNION
OF THE UNITED STATES OF AMERICA
MEMBERSHIP LIST
FOR THE YEAR 1900
Name Address City State
Mrs. J. W. Smith 123 Main St. New York N.Y.
Mrs. A. B. Jones 456 Elm St. Boston Mass.
Mrs. C. D. White 789 Oak St. Chicago Ill.
Mrs. E. F. Green 101 Pine St. Philadelphia Pa.
Mrs. G. H. Black 202 Cedar St. St. Louis Mo.
Mrs. I. J. Brown 303 Maple St. Cincinnati Ohio
Mrs. K. L. Gray 404 Birch St. Portland Me.
Mrs. M. N. Hall 505 Spruce St. Seattle Wash.
Mrs. O. P. King 606 Fir St. San Francisco Cal.
Mrs. Q. R. Lee 707 Willow St. Denver Colo.
Mrs. S. T. Young 808 Ash St. Salt Lake City Utah
Mrs. U. V. Wright 909 Hickory St. Omaha Neb.
Mrs. W. X. Scott 1010 Sycamore St. Kansas City Mo.
Mrs. Y. Z. Adams 1111 Walnut St. St. Paul Minn.
Mrs. A. B. Baker 1212 Chestnut St. Minneapolis Wis.
Mrs. C. D. Carter 1313 Elm St. Milwaukee Wis.
Mrs. E. F. Evans 1414 Maple St. Indianapolis Ind.
Mrs. G. H. Fisher 1515 Pine St. Cincinnati Ohio
Mrs. I. J. Gibson 1616 Oak St. Columbus Miss.
Mrs. K. L. Hall 1717 Birch St. Mobile Ala.
Mrs. M. N. Harris 1818 Spruce St. Montgomery Ala.
Mrs. O. P. Hill 1919 Fir St. Birmingham Ala.
Mrs. Q. R. Howell 2020 Willow St. Tallahassee Fla.
Mrs. S. T. Hunt 2121 Ash St. Jacksonville Fla.
Mrs. U. V. Ingram 2222 Hickory St. Pensacola Fla.
Mrs. W. X. Jackson 2323 Sycamore St. Panama City Fla.
Mrs. Y. Z. Johnson 2424 Walnut St. Tallahassee Fla.
Mrs. A. B. Keith 2525 Chestnut St. Tallahassee Fla.
Mrs. C. D. Lester 2626 Elm St. Tallahassee Fla.
Mrs. E. F. Lewis 2727 Maple St. Tallahassee Fla.
Mrs. G. H. Martin 2828 Pine St. Tallahassee Fla.
Mrs. I. J. Miller 2929 Oak St. Tallahassee Fla.
Mrs. K. L. Moore 3030 Birch St. Tallahassee Fla.
Mrs. M. N. Myers 3131 Spruce St. Tallahassee Fla.
Mrs. O. P. Nichols 3232 Fir St. Tallahassee Fla.
Mrs. Q. R. Oliver 3333 Willow St. Tallahassee Fla.
Mrs. S. T. Parker 3434 Ash St. Tallahassee Fla.
Mrs. U. V. Quinn 3535 Hickory St. Tallahassee Fla.
Mrs. W. X. Roberts 3636 Sycamore St. Tallahassee Fla.
Mrs. Y. Z. Russell 3737 Walnut St. Tallahassee Fla.
Mrs. A. B. Sanders 3838 Chestnut St. Tallahassee Fla.
Mrs. C. D. Shaw 3939 Elm St. Tallahassee Fla.
Mrs. E. F. Stone 4040 Maple St. Tallahassee Fla.
Mrs. G. H. Taylor 4141 Pine St. Tallahassee Fla.
Mrs. I. J. Turner 4242 Oak St. Tallahassee Fla.
Mrs. K. L. Vance 4343 Birch St. Tallahassee Fla.
Mrs. M. N. Warren 4444 Spruce St. Tallahassee Fla.
Mrs. O. P. Webb 4545 Fir St. Tallahassee Fla.
Mrs. Q. R. White 4646 Willow St. Tallahassee Fla.
Mrs. S. T. Wilson 4747 Ash St. Tallahassee Fla.
Mrs. U. V. Wood 4848 Hickory St. Tallahassee Fla.
Mrs. W. X. Wright 4949 Sycamore St. Tallahassee Fla.
Mrs. Y. Z. Young 5050 Walnut St. Tallahassee Fla.
Mrs. A. B. Zachary 5151 Chestnut St. Tallahassee Fla.
Mrs. C. D. Adams 5252 Elm St. Tallahassee Fla.
Mrs. E. F. Baker 5353 Maple St. Tallahassee Fla.
Mrs. G. H. Carter 5454 Pine St. Tallahassee Fla.
Mrs. I. J. Evans 5555 Oak St. Tallahassee Fla.
Mrs. K. L. Fisher 5656 Birch St. Tallahassee Fla.
Mrs. M. N. Gibson 5757 Spruce St. Tallahassee Fla.
Mrs. O. P. Hall 5858 Fir St. Tallahassee Fla.
Mrs. Q. R. Harris 5959 Willow St. Tallahassee Fla.
Mrs. S. T. Hill 6060 Ash St. Tallahassee Fla.
Mrs. U. V. Hunt 6161 Hickory St. Tallahassee Fla.
Mrs. W. X. Ingram 6262 Sycamore St. Tallahassee Fla.
Mrs. Y. Z. Jackson 6363 Walnut St. Tallahassee Fla.
Mrs. A. B. Keith 6464 Chestnut St. Tallahassee Fla.
Mrs. C. D. Lester 6565 Elm St. Tallahassee Fla.
Mrs. E. F. Lewis 6666 Maple St. Tallahassee Fla.
Mrs. G. H. Martin 6767 Pine St. Tallahassee Fla.
Mrs. I. J. Miller 6868 Oak St. Tallahassee Fla.
Mrs. K. L. Moore 6969 Birch St. Tallahassee Fla.
Mrs. M. N. Myers 7070 Spruce St. Tallahassee Fla.
Mrs. O. P. Nichols 7171 Fir St. Tallahassee Fla.
Mrs. Q. R. Oliver 7272 Willow St. Tallahassee Fla.
Mrs. S. T. Parker 7373 Ash St. Tallahassee Fla.
Mrs. U. V. Quinn 7474 Hickory St. Tallahassee Fla.
Mrs. W. X. Roberts 7575 Sycamore St. Tallahassee Fla.
Mrs. Y. Z. Russell 7676 Walnut St. Tallahassee Fla.
Mrs. A. B. Sanders 7777 Chestnut St. Tallahassee Fla.
Mrs. C. D. Shaw 7878 Elm St. Tallahassee Fla.
Mrs. E. F. Stone 7979 Maple St. Tallahassee Fla.
Mrs. G. H. Taylor 8080 Pine St. Tallahassee Fla.
Mrs. I. J. Turner 8181 Oak St. Tallahassee Fla.
Mrs. K. L. Vance 8282 Birch St. Tallahassee Fla.
Mrs. M. N. Warren 8383 Spruce St. Tallahassee Fla.
Mrs. O. P. Webb 8484 Fir St. Tallahassee Fla.
Mrs. Q. R. White 8585 Willow St. Tallahassee Fla.
Mrs. S. T. Wilson 8686 Ash St. Tallahassee Fla.
Mrs. U. V. Wood 8787 Hickory St. Tallahassee Fla.
Mrs. W. X. Wright 8888 Sycamore St. Tallahassee Fla.
Mrs. Y. Z. Young 8989 Walnut St. Tallahassee Fla.
Mrs. A. B. Zachary 9090 Chestnut St. Tallahassee Fla.
Mrs. C. D. Adams 9191 Elm St. Tallahassee Fla.
Mrs. E. F. Baker 9292 Maple St. Tallahassee Fla.
Mrs. G. H. Carter 9393 Pine St. Tallahassee Fla.
Mrs. I. J. Evans 9494 Oak St. Tallahassee Fla.
Mrs. K. L. Fisher 9595 Birch St. Tallahassee Fla.
Mrs. M. N. Gibson 9696 Spruce St. Tallahassee Fla.
Mrs. O. P. Hall 9797 Fir St. Tallahassee Fla.
Mrs. Q. R. Harris 9898 Willow St. Tallahassee Fla.
Mrs. S. T. Hill 9999 Ash St. Tallahassee Fla.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 81 00195 REG. NO. | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Betty</u> MIDDLE <u>Ann</u> LAST <u>Marsh</u> | | | | 2a. DATE OF DEATH MONTH <u>1</u> DAY <u>11</u> YEAR <u>81</u> | | | |
| 3. SEX <u>Female</u> | | | | 2b. HOUR <u>6:25</u> P.M. | | | |
| 4. RACE <u>Caucasion</u> | | 5. DATE OF BIRTH MONTH <u>Dec.</u> DAY <u>16</u> YEAR <u>1925</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>55</u> YRS. | | IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Anne Arundel Co.</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Annapolis</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Anne Arundel General</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 13a. STATE <u>Maryland</u> 13b. COUNTY <u>A.A.CO.</u> 13c. CITY OR TOWN <u>Ferndale</u> | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST <u>William H.</u> MIDDLE <u></u> LAST <u>Thomas</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST <u>Ruth</u> MIDDLE <u>N.</u> LAST <u>White</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | | | 16b. SOCIAL SECURITY NO. <u>212-26-5943</u> | | | |
| 17. INFORMANT ADDRESS <u>William H. Marsh same as 13</u> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca BREAST</u> <u>1749</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u></u> (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1958</u> , 19 <u> </u> , to <u>1/14/81</u> , 19 <u> </u> , that (I) (we) lost saw the deceased alive on <u>1/11/81</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Stanley Watkins</u> DEGREE <u></u> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>1/13/81</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>STANLEY WATKINS</u> | | | | 22e. ADDRESS <u>121 Cathedral St. Annapolis Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>1/14/81</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Brooklyn A.A.Co. Md.</u> | |
| 24. FUNERAL DIRECTOR NAME <u>James S. Kirkley</u> ADDRESS <u>421 Crain Hwy</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 13 1981</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 81 00196 | | | |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANN S MARTIN | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-31-81 | | 2b. HOUR 1045 pm | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 5-19-34 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 46 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL CO. ANNAPOLIS MD. | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS MD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) General | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REGISTERED NURSE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD. | | 13b. COUNTY A.A. CO. | | 13c. CITY OR TOWN ANNAPOLIS | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM S SHAVER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUCILE SANFORD | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | |
| | | 16b. SOCIAL SECURITY NO. 815-30-6915 | | 17. INFORMANT ADDRESS THOMAS J. MARTIN #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) central bleed 2362 DUE TO, OR AS A CONSEQUENCE OF (b) granulosa cell tumor of ovary DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1978 , 19____, to 1/31/81 , 19____, that (I) (we) last saw the deceased alive on 1/30/81 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Stanley P. Watkins Jr | | DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 2/4/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY P. WATKINS JR | | 22e. ADDRESS 121 CATH. ST. ANNAPOLIS MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) ENTOMBMENT | | 23b. DATE 2-3-81 | | 23c. NAME OF CEMETERY OR CREMATORY HILLCREST GEN. | | 23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS A.A. MD. | |
| 24. FUNERAL DIRECTOR NAME JOHN M. TAYLOR & SONS | | | | ADDRESS ANNAPOLIS MD | | 25a. DATE REC'D. BY REGISTRAR FEB 3 1981 | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 355-5935.

DHMH-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 810019E.7.T | | | |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES MCKINLEY MARTIN | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 20, 1981 | | | |
| 3 SEX M | | | | 2b. HOUR A.M. 5:32 M | | | |
| 4 RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 4 23 1902 | | 6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY SEAFOOD | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY Somerset 13c. CITY OR TOWN Kingston | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 90 P.O. Marion Md. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ROMEO Martin | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SALLY Horsley | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 216-09-3567 | | 17. INFORMANT ADDRESS Bersada Martine-Kingston Md. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE M. Kaplan | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/24/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARC A. KAPLAN, M.D. | | | | 22e. ADDRESS 325 HOSPITAL DRIVE, SUITE 201 GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/24/81 | | 23c. NAME OF CEMETERY OR CREMATORY Kingston | | 23d. LOCATION CITY OR TOWN COUNTY STATE Kingston | |
| 24. FUNERAL DIRECTOR NAME Anthony E. Ward | | | | ADDRESS Cinco, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 23 1981 | |
| | | | | 25b. RECEIVED BY [Signature] | | | |

001 31A
JANUARY 20, 1981 12:25

WILLIAM Y. MARTIN

CH-113

ATLANTA-DEKALB COUNTY

LEWIS BURRILL FORT RUSSELL HOSPITAL

300 HOSPITAL DRIVE, SUITE 20
LEWIS BURRILL, FORT RUSSELL

MRS. A. BURRILL, M.D.

JAN 23 1981

TO HOSPITAL-ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8100198 | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SUSAN Hutchinson MARTIN | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 27-81 | | 2b. HOUR 7:20 P.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 20, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 77 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Montana | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Annapolis Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Professor | | 12b. KIND OF BUSINESS OR INDUSTRY College | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MD A.A. Annapolis | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Bay Ridge Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ernest Douglas Martin | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Hutchinson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 4292 | | 17. INFORMANT ADDRESS Capt. W.A.P. Martin 2 St. Mary's Street Annapolis, MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>fracture</u> <u>Whip</u> <u>1978</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/9</u> , 19 <u>78</u> , to <u>1/27</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>12/10</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Rodney L. Brimhall | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/27/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rodney L. Brimhall, MD. | | | | 22e. ADDRESS 1419 Forest Drive Annapolis, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan 30, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis, MD | |
| 24. FUNERAL DIRECTOR NAME John M. Taylor & Sons, Annapolis, MD | | | | 25a. DATE RECORDED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | |



Female White April 20, 1903
 Montana USA

Mr. A.A. Annabols
 Annabols during time Professor College

Forest Douglas Martin Clara
 No

Copy W.A. F. Martin
 Annabols M.D.

Annabols M.D.
 251 Maryland Street

Annabols M.D.
 251 Maryland Street

Annabols M.D.
 251 Maryland Street

Annabols M.D.
 251 Maryland Street

Annabols M.D.
 251 Maryland Street

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 0 1 9 9

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Jerry A Marx | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 8 81 | | | 2b. HOUR 4:35 AM | | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 9 16 38 | | 6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A.A.G.H. | | | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver | | 12b. KIND OF BUSINESS OR INDUSTRY Bus | | |
| 13a. STATE Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN Annapolis | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 904 Bay Front CUE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Marx | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Dodlin | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1958 | | 17. INFORMANT 212-36-2593 | | | ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor 2396 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/1/80 , 19 80 , to 1/17/81 , 19 81 , that (I) (we) last saw the deceased alive on 1/17/81 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Jack Kushner | | | | | DEGREE MD | | | 22c. DATE SIGNED 1/18/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack Kushner | | | | | 22e. ADDRESS 20 Ridgely - Annapolis, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | | 23b. DATE 1/8/81 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | | ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 26 1981 | | 25b. REGISTRAR'S SIGNATURE Robert McCready | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

James Buchanan

Driver

Post Office

Address

State

City

1858

1858

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 1 | 0 | 0 | 2 | 0 | 0 |
|---|--|---|--|---|---|--|---|--|--------------------------------|---|-------------------------------|---|---|--------------------|---|---|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Edward McKee | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 28 81 | | | | 2b. HOUR 1120 M | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 4 1920 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7. IF UNDER 24 HRS. HOURS MIN | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Ft. Meade, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kimbrough Army Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY Frieght Co. | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Anne Arunde Ft. Meade | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 8018B Leslie Road, Ft. Meade | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John McKee | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Loretta Ford | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes/4 1/2 yrs. WWII | | 16b. SOCIAL SECURITY NO. 15314 69 33 | | 17. INFORMANT ADDRESS Loretta McCrudden/Daughter - 8018B Leslie Rd. Ft. Meade, Md. | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CVA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 minute 3 days | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Carotid Artery Stenosis Hypertension.</u> | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>25 Jan 1981</u> , 19 <u>81</u> , to <u>28 Jan</u> , 19 <u>81</u> , that (I) (we) lost the deceased alive on <u>28 Jan</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did XXXX view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Carlene Hawksley, Cpt, MC</u> | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 28 Jan 81 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carlene Hawksley, CPT, MC | | | | | | 22e. ADDRESS Kimbrough Army Hospital, Ft Meade, Md. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/2/81 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE North Arlington, Bergen NJ | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Fleck Funeral Home, Laurel, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 2 1981 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8100201 | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST June Lucille McKnight | | | | January 7, 1981 2:45pm | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 18, 1934 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 46 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH Millersville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 48 Rol Park Trailer Court | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. STATE Md. | | 13b. COUNTY AA | | 13c. CITY OR TOWN Millersville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William L. Manning | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna F. Chew | | 16. STREET ADDRESS 48 Rol Park Trailer Ct. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, AND OR UNKNOWN) [IF YES, GIVE WAR OR DATES] No | | 16b. SOCIAL SECURITY NO. 215-30-6228 | | 17. INFORMANT ADDRESS Donald G. McKnight, Husband, same as 17 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer - Sarcoma of ovary</u> 1830 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>abuse</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Vaginal bleeding</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Vaginal bleeding</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1980</u> to <u>1-7, 1981</u> , that (I) (we) last saw the deceased alive on <u>12-4-80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Jaime Accinelli</u> DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 8 Jan. 81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jaime Accinelli, M.D. | | | | 22e. ADDRESS 325 Hospital Drive, Glen Burnie, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10 Jan. 81 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, AA, Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, Md. | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 9 1981 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8100202 | |
|--|---|---|---|---|---|
| 1. FOR STATE REGISTRAR | | CERTIFICATE OF DEATH | | REG. NO. EST | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST Laurence MIDDLE I. LAST MELDROM | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 30, 1981 | | 2b. HOUR 7:30 PM |
| 3 SEX Male | 4 RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR Apr. 15, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Quality Control | | 12b. KIND OF BUSINESS OR INDUSTRY Retired |
| 13a. STATE Md. | | | 13b. COUNTY AA | 13c. CITY OR TOWN Glen Burnie | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William T. Meldrom | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma May Thompson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214-01-2320 | | 17. INFORMANT ADDRESS L. J. Meldrom, 220 Glen Burnie, Md. 220 Wicklow Ave, Ferndale | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-22 , 19 81 , to 1-30 , 19 81 , that (I) (we) last saw the deceased alive on 1-30 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Sang C. Doh DEGREE | | | | 22c. DATE SIGNED 1-31-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANG C. DOH, M.D. | | | | 22e. ADDRESS 95 AQUAHART RD. GLEN BURNIE, MD. 21061 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3 Feb. 81 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | |
| 23d. LOCATION CITY OR TOWN Baltimore | | 23e. COUNTY Md. | | 23f. STATE Md. | |
| 24. FUNERAL DIRECTOR James S. Kirkley, Glen Burnie | | | | 25a. DATE REC'D. BY REGISTRAR FEB 2 1981 | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

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|--|---|---|--|---|---------------------|
| 1. DECEASED NAME (TYPE OR PRINT) CALVIN LEWIS MILLER | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 15, 1981 | | 2b. HOUR 3:30 PM |
| 3. SEX Male White | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 7, 1897 | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Postmaster | 12b. KIND OF BUSINESS OR INDUSTRY US Gov. | |

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| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md | | | 13b. COUNTY AACo | 13c. CITY OR TOWN Gambrills | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS P.O. Box 156 |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Henry Miller | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilhelminia Wesselman | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes | | 16b. SOCIAL SECURITY NO. 214 44 9570 | | 17. INFORMANT Nancy Jacobs, Linthicum, Md | | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-respiratory arrest</i> 4380 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Obstructive pulmonary disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Coronary heart failure</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
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| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Fracture right hip</i> | | | |
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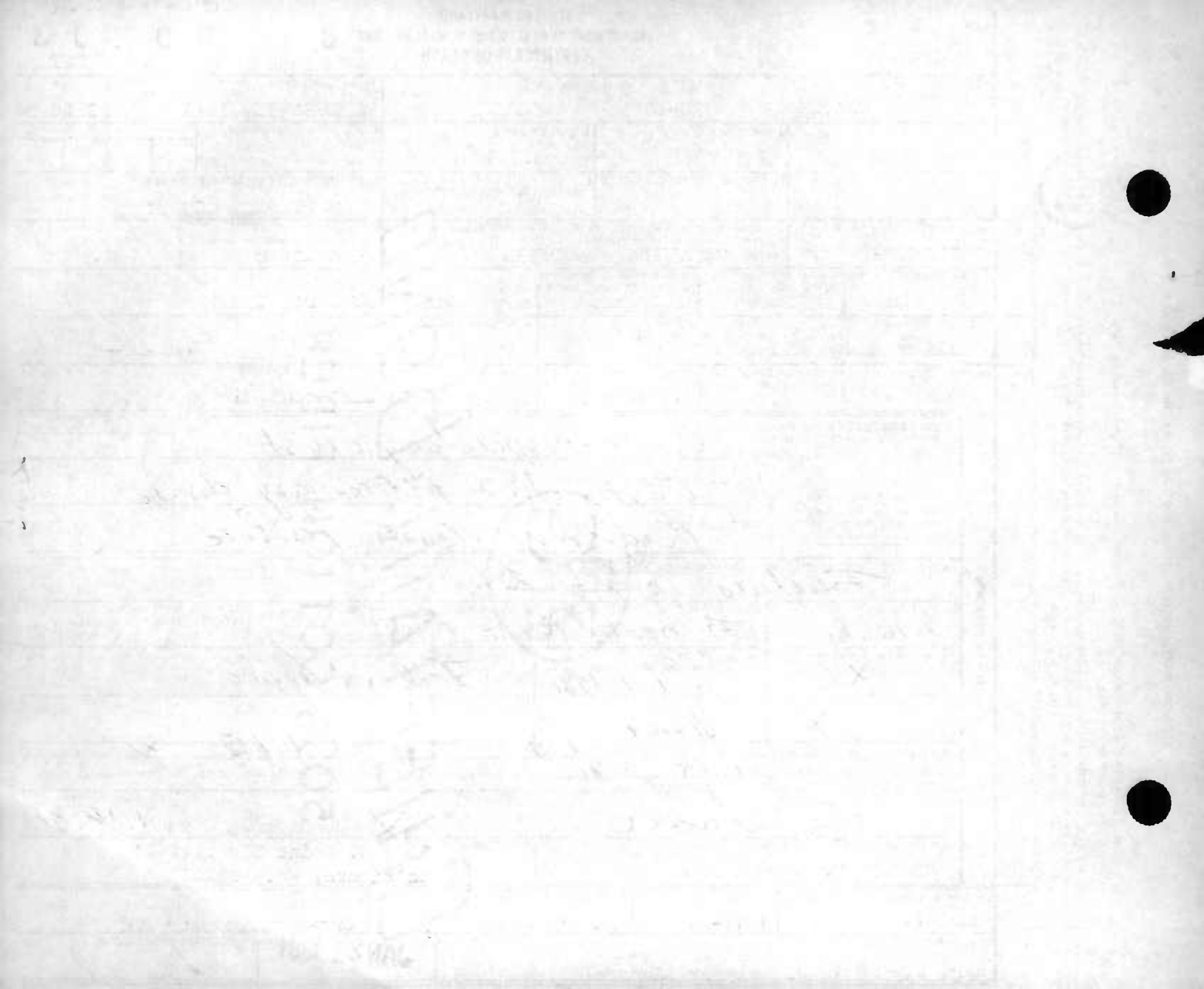
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|---|---|---|--|
| 19a. DATE OF OPERATION 1.10.81 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Fr. neck right femur</i> | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 1.1.1986 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>Fell in home</i> | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>Home</i> | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

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| 22a. I certify that (I) (this hospital) attended the deceased from 1.9.81, to 1.15.81, that (I) (we) last saw the deceased alive on 1.15.81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | |
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| 22b. SIGNATURE <i>G. Lazar</i> | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 1.16.81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE T. LAZAR, M.D. | 22e. ADDRESS 1103 N. Point Blvd., #404 Baltimore, Md. 21224 | |

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|--|----------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1-17-81 | 23c. NAME OF CEMETERY OR CREMATORY St Stephens | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville AACo Md |
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| 24. FUNERAL DIRECTOR NAME ADDRESS Hardesty FH, 12 Ridgely Ave, Annapolis, Md. 21401 | 25a. DATE RECEIVED BY REGISTRAR JAN 21 1981 | 25b. REGISTRAR'S SIGNATURE |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO. EST

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|---|--|---|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM R. MILLER, SR. | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 19, 1981 | | | 2b. HOUR 6:30 P _M | | | | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR September 2, 1892 | | 6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | |
| 10 CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Head Matre De--Hotel | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Balto. Highland | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 3925 Mc Dowell Lane 21227 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST John Melvin Miller | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | 16b. SOCIAL SECURITY NO. WW 1 217-03-3436 | | 17 INFORMANT ADDRESS Mr. Martin Miller 532 Alden Street 21225 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-pulmonary arrest 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease, Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Severe Polycythemia ; @ Inguinal Hernia. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/9/1981 to 1/19/1981, that (I) (we) lost saw the deceased alive on 1/19/1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE H. Bhasin | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 1/20/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARI K. BHASIN, M.D. | | | 22e. ADDRESS 1404 Crain Hwy. S. #300 Glen Burnie, Md. 21061 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/22/81 | | 23c. NAME OF CEMETERY OR CREMATORY Crownsville Vet. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville Anne Arundel Md. | | | |
| 24 FUNERAL DIRECTOR NAME Mc Cully Funeral Home of Brooklyn | | | 24b. ADDRESS 237 E. Patapsco Avenue Balto., Md. 21225 | | | 25a. DATE REC'D. BY REGISTRAR JAN 22 1981 | | 25b. REGISTRAR'S SIGNATURE R. J. McHenry | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 1 0 0 2 0 5 REG. NO. | |
|--|--|---|--|---|--|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) EDNA W. MORGAN | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 9, 1981 | | | 2b. HOUR 7:26 A | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 5, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | |
| 13a. STATE Maryland | | | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Peed | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thomas B. Seifert Timonium, Md. 21093 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-07-1981 | | 17. INFORMANT ADDRESS Thomas B. Seifert Timonium, Md. 21093 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| Oxygenation Brain Syndrome | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/27, 1980, to 1/9, 1981, that (I) (we) last saw the deceased alive on 1/9, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Robert B. Kroopnick | | | | | | DEGREE M.D. | | 22c. DATE SIGNED 1/12/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT B. KROOPNICK, M.D. | | | | | | 22e. ADDRESS 205 BALTIMORE-ANNAPOLIS BOULEVARD GLEN BURNIE, MARYLAND 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Jan. 12, '81 | | 23c. NAME OF CEMETERY OR CREMATORY Mem. Pk. Baltimore Co., Md. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME William E. Johnson | | | | ADDRESS 8521 Loch Raven Blvd. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE R. J. Kelly | |

DATE _____ TIME _____

485 S. 19th St.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| FOR 1 - STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 0 0 2 0 6 | | | |
|---|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| Edith S. Morse | | | | 1 26 81 | | | | 6:15 AM | | | |
| 3. SEX F | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH 11 DAY 17 YEAR 86 | | 6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vermont | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH AA County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Crofton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Crofton Convalescent Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) nurse | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| 13a. STATE md. | | 13b. COUNTY AA | | 13c. CITY OR TOWN Annapolis | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 320 Clapstone Hill | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Baden Sheddric | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia E. Smith | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) — | | 17. INFORMANT Mrs. Elizabeth W. | | ADDRESS 444 Ellwood Ct | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cardio Respiratory Arrest | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| Alzheimer's Disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/15 1980, to 1/26 1981, that (I) (we) last saw the deceased alive on 1/23 1981, and that in (my) (our) opinion death occurred on the 26th day of 1981 and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.) | | | | | | | | | | | |
| 22b. SIGNATURE James Charles W. | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. RHODES MD | | | | 22e. ADDRESS 1667 Crofton Center Crofton, Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL CREMATION | | 23b. DATE 1/27/81 | | 23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BETHWOOD P.G. MD | | | |
| 24. FUNERAL DIRECTOR John M. Layher | | | | ADDRESS Southeastern, Md. | | | | 25a. DATE REC'D. BY REGISTRAR FEB 5 1981 | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE History McCreedy | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8100207 | |
|---|------------------------|---|---|--|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) <u>Mosteller Simon</u> | | | 2a. DATE OF DEATH MONTH <u>1</u> DAY <u>28</u> YEAR <u>81</u> | | 2b. HOUR <u>1 A</u> M |
| 3 SEX <u>Male</u> | 4 RACE <u>White</u> | 5. DATE OF BIRTH MONTH <u>March</u> DAY <u>8</u> YEAR <u>1911</u> | | 6 AGE (IN YEARS LAST BIRTHDAY) <u>69</u> YRS. | IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>North Carolina</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Anne Arundel</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Annapolis</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Anne Arundel General Hospital</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Guard</u> | |
| 13a. STATE <u>Maryland</u> | | 13b. COUNTY <u>Baltimore</u> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS <u>626 Soth Newkirk St</u> | |
| 14. FATHER'S NAME FIRST <u>Lucius</u> MIDDLE <u>B</u> LAST <u>Mosteller</u> | | 15. MOTHER'S MAIDEN NAME FIRST <u>Mary</u> MIDDLE <u>E</u> LAST <u>Pruitt</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | 16b. SOCIAL SECURITY NO. <u>216-03-5778</u> | | 17. INFORMANT ADDRESS <u>Mr Ronald L Mosteller 4262 Sheldon Ave</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>5140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic heart syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from <u>1-27</u> , 19 <u>81</u> , to <u>1-28</u> , 19 <u>81</u> , that (we) last saw the deceased alive on <u>1-27</u> , 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>GAMitchell MD</u> | | | | 22c. DATE SIGNED <u>1-28-81</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GAMitchell MD</u> | | | | 22e. ADDRESS <u>1616 Forest Dr. Annapolis</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>1/31/81</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Damascus</u> | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Gordon County Ga.</u> | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 29 1981</u> | | | |
| 24. FUNERAL DIRECTOR NAME <u>Leonard J Ruck Inc</u> | | ADDRESS <u>Baltimore, Maryland</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 1 | 00208 | | | |
|--|--|--|--|--|--------------------------|--|--|--|---|--|------------------|--|--|-----------------|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | |
| BESSIE MN MUNDALL | | | | | | | | | | JANUARY 24, 1981 | | | | 5:11P M | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | | Black | | | 7 2 97 | | | 83 YRS. | | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Virginia | | | U.S.A. | | | | | | ANNE ARUNDEL COUNTY MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| GLEN BURNIE | | | NORTH ARUNDEL HOSPITAL | | | | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1425 Dorsey Road | | | | |
| Maryland | | | A.A. | | | Hanover | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| Louis Jackson | | | | | Pinkey Jackson | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | |
| | | | | | 212-32-3272 | | | | | 1128 Crain Highway Clara Garland Glen Burnie-Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic carcinoma of colon</i> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>months</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | |
| <i>Sang C. DoH</i> | | | | 1-24-81 | | | | SANG C. DOH, M.D. | | | | | | | |
| 22e. ADDRESS | | | | 22f. ADDRESS | | | | 22g. ADDRESS | | | | | | | |
| 95 AQUAHART ROAD | | | | GLEN BURNIE, MARYLAND 21061 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 1-28-81 | | | | Church Cem. | | | | Hanover Md. | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 24a. DATE REC'D. BY REGISTRAR | | | | 24b. REGISTRAR'S SIGNATURE | | | | | | | |
| Chas. A. Rice FSPA 1300 Eutaw Pl. | | | | FEB 3 1981 | | | | <i>Christy H. Harty</i> | | | | | | | |

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31/01/2010

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75000

all

GLENN BURRITT, HAYWARD 51081
62 WILMART ROAD

2146 C. DOH, M.D.

18-02-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 0 2 0 9 | |
|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| CERTIFICATE OF DEATH | | | | E.S.T. | |
| 1. DECEASED NAME (TYPE OR PRINT) GEORGE WILLIAM MURPHY, SR. | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 9, 1981 | | 2b. HOUR MIN. 6:20 A.M. |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR NOV. 9, 1897 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 83 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stationery Eng. | 12b. KIND OF BUSINESS OR INDUSTRY Md.St.Gov't. | |
| 13a. STATE Maryland | | | 13b. COUNTY A.A. | 13c. CITY OR TOWN Severn | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Murphy | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosemary McCarty | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. W.W. I 213.03.8878 | 17. INFORMANT ADDRESS Woodbine, Md., Mr. John CM. Murphy (Son) 21797 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Cardio-respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Ventricular arrhythmia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Basant K. Khandelwal | | DEGREE M.D. | | 22c. DATE SIGNED 1/9/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BASANT K. KHADELWAL, M.D. | | 22e. ADDRESS 205 BALTIMORE-ANAPOLIS BOULEVARD GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | 23b. DATE 9 JAN. 81 | 23c. NAME OF CEMETERY OR CREMATORY Security Process | | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balt. MD. | |
| 24. FUNERAL DIRECTOR NAME Singleton Funeral Home | | ADDRESS Glen Burnie Maryland | | 25a. DATE REC'D. BY REGISTRAR JAN 12 1981 | 25b. REGISTRAR'S SIGNATURE [Signature] |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8100210 EST REG. NO. | | | | |
|---|--|---|--|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) EMELIA K. MYERS | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 29, 1981 | | | | 2b. HOUR 1:30 P M |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 27, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 74 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE, TRADE, PROFESSION, OR WORK OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY A. A. | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Julius = Kelm | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christina = Bollinger | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 705-05-4072-A | | 17. INFORMANT ADDRESS Edward Mount 425 Fernwood Br. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardio Pulmonary Arrest 5715 DUE TO, OR AS A CONSEQUENCE OF (b) Gastrointestinal Bleeding Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Chronic Cirrhosis with Varices Esophagael PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from 12-11 , 19 80 , to 1-29 , 19 81 , that (I) (we) last saw the deceased alive on 1-29 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | 22c. DATE SIGNED 1-29-81 |
| 22b. SIGNATURE Ed Sherman | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD SHERMAN M.D. | | | | 22e. ADDRESS 205 BALTIMORE & ANNAPOLIS BOULEVARD GLEN BURNIE, MARYLAND 21061 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/2/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A. A. Md. | | |
| 24. FUNERAL DIRECTOR NAME Raymond C. Fink | | | | ADDRESS Glen Burnie, Md. | | 25. DATE REC'D. BY REGISTRAR FEB 3 1981 | | |

JANUARY 20, 1961 1:30P

RECEIVED

RECEIVED

WAVE ABUNDANT COUNTY

U.S.A.

RECEIVED

NORTH AMERICAN HOSPITAL

CLIN BUREAU

11. 10. 1960

11. 10. 1960

11. 10. 1960

11. 10. 1960

11. 10. 1960

11. 10. 1960

11. 10. 1960

11. 10. 1960

11. 10. 1960

[Handwritten notes and signatures]

305 BALTIC ST. BALTIMORE 2, MARYLAND

CLIN BUREAU, BALTIMORE 2, MARYLAND

EDWARD SHIMAN, M.D.

1961

CLIN BUREAU, BALTIMORE 2, MARYLAND

EDWARD SHIMAN, M.D.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00211

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | |
|---|---------|--|--|---|---|---|--------------------------------------|-------------------------------|--------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2b. DATE KNOWN OF DEATH | | ESTI- MATED | MONTH | DAY | YEAR | 2b. HOUR |
| Thomas Anthony MYERS | | | | | 1 3 1981 | | | | | | A M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | IF UNDER 1 YR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR |
| M | W | 12 6 23 | | 57 YRS. | MONTHS DAYS HOURS MIN | | | | 1 3 1981 | | A M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Washington D.C. | | USA | | | | | ANNE ARUNDEL MD | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Annapolis | | ANNE ARUNDEL - General | | | systems analyst | | St. of Md. | | | | |
| 13a. STATE | | | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | | | |
| Md. | | | | A.A. Co. | West River | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 4921 Muddy Creek Rd. | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| FIRST MIDDLE LAST Thomas Anthony Myers Sr. | | | | | FIRST MIDDLE LAST Blanche Agnes Tebbs | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| yes | | | 43-63 | | Mary Muriel Myers same as 13e. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | STATE |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | M.D. | | | DATE SIGNED | | |
| E. Linhardt | | | Deputy 9 | | | MEDICAL EXAMINER | | | 1-3-81 | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | | | | |
| E. Linhardt | | | Annapolis, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 1/6/81 | | Our Lady of Sorrows | | West River Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Hardesty Funeral Home | | | | 12 Ridgely Ave. Ann. Md. | | | | JAN 6 1981 | | [Signature] | |

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP _____

DHMH-16 20M
(VRA 15, 4) 7/78

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8100212 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Michiko — Nakamura</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>Jan. 14, 1981</i> | | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>Oriental</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>April 26, 1938</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>42</i> YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Japan</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Pasadena, A.A.Co.</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Pasadena</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>7728 Ford Dr. Pasadena, Md.</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Reg. Nurse</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>A.A.Co.</i> | | 13c. CITY OR TOWN <i>Pasadena</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Kenkichi — Nakamura</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Misao Unknown</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>212-54-9634</i> | | 17. INFORMANT ADDRESS <i>Gardner Stanke, Same as above</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>RECTAL CARCINOMA</i> <i>154</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>THURMAN H</i> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>March 22</i> 19 <i>81</i> , to <i>Jan 14</i> 19 <i>81</i> , that (I) (we) lost <i>know</i> the deceased alive on <i>Jan 14</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Diana H. Griffiths</i> | | DEGREE <i>M.D.</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>1/14/81</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Diana H. Griffiths, M.D.</i> | | 22e. ADDRESS <i>900 Caton Ave. 21227</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i> | | 23b. DATE <i>Jan. 14, 1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Security Crematory Process</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Catonville, Balto. Co. Md.</i> | |
| 24. FUNERAL DIRECTOR <i>McCutty Funeral Home, Mt. & Tickneck Rds. Pasadena</i> | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 21 1981</i> | | 25b. REGISTRAR'S SIGNATURE <i>Jeffrey H. Harty</i> | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 0 0 2 1 3 REG. NO. EST | |
|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANK THOMAS NOVAK | | | JANUARY 16, 1981 | | 2b. HOUR 7:13 PM |
| 3 SEX MALE | 4 RACE WHITE | 5 DATE OF BIRTH MONTH DAY YEAR FEB. 3, 1893 | 6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | |
| 10 CITY OR TOWN OF DEATH GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Grocer | 12b. KIND OF BUSINESS OR INDUSTRY Grocery | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY A.A. | 13c. CITY OR TOWN Pasadena | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14 FATHER'S NAME FIRST MIDDLE LAST THOMAS NOVAK | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ===== | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.I. 220 22 2142 | 17 INFORMANT ADDRESS Tillie V. Novak, same as 13e | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>congestive heart failure</i> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>weeks</i> <i>years</i> | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-2</i> , 19 <i>81</i> , to <i>1-16</i> , 19 <i>81</i> , that (I) (we) lost saw the deceased alive on <i>1-16</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and I) did not view the body after death. | | | | | |
| 22b. SIGNATURE <i>Sang C. Doh</i> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>1-16-81</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANG C. DOH, M.D. | | 22e. ADDRESS 95 Aquahart Rd. Glen Burnie, Md. 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Jan. 19, 1981 | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A. Co., Maryland | |
| 24 FUNERAL DIRECTOR NAME George J. Gonce | | ADDRESS 4001 Ritchie Hg., Baltimore, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 19 1981 | 25b. REGISTRAR'S SIGNATURE <i>Robert M. Brady</i> |

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 0 2 1 4

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | |
|---|--|---|---|---|-------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM Franklin NULL SR. | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 19 81 | | 2b. HOUR 7A M | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 6 18 20 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 10 CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital | | 9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD. | | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Glen Burnie | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Herbert Sanford NULL | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie V. Clark | | 12b. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Machinist | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 223-12-6575 | | 17 INFORMANT ADDRESS Mrs. Niza L. Null Same as #13 | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exacerbated brain damage 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last b) Cerebral aneurysm c) ASIA DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/15/81 to 1/18/81 , 19 81 , that (I) (we) last saw the deceased alive on 1/15/81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE R. Bienn | | DEGREE Robert O. Bienn, M.D. | | 22c. DATE SIGNED 1/19/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS Anne Arundel Gen. Hospital, Annapolis, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/22/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem. | | |
| 24 FUNERAL DIRECTOR NAME Mc Cully F.H. Mtn. & Tick Neck Rds., Pasadena, Md. | | 24b. ADDRESS 21122 | | 24c. LOCATION CITY OR TOWN COUNTY STATE Crownsville, Anne Arundel, Md. | | |
| 25a. DATE REC'D. BY REGISTRAR JAN 21 1981 | | 25b. REGISTRAR'S SIGNATURE P. J. Kebedy | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 0 2 1 5

| | | | |
|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Lillian Day NYE | | 7a. DATE OF DEATH MONTH DAY YEAR Jan 9, 1981 | |
| 2. SEX Female | | 7b. HOUR 6:35 PM | |
| 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 18, 1891 | |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West River, Md | | 8. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | |
| 7d. CITIZEN OF WHAT COUNTRY? USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH AA Co MD. | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AA General | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md | | 13b. COUNTY AA Co | |
| 13c. CITY OR TOWN Harwood | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edgar Shepherd | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Stanforth | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 214 74 8806 | |
| 17. INFORMANT ADDRESS Joseph Emmerich, Lothian, Md | | | |
| 18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (b) 4409 DUE TO, OR AS A CONSEQUENCE OF (c) year | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | |
| 19a. DATE OF OPERATION none | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR NO injury | |
| 21c. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — | |
| 21e. LOCATION CITY OR TOWN COUNTY STATE — | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from November 3, 1980 to January 9, 1981 , the (I) (we) last saw the deceased alive on 11/9/81 19 — and that in my (our) opinion death occurred on the day and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Charles H. Wirth, M.D. DEGREE — | | 22c. DATE SIGNED 1/10/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles H. Wirth, M.D. | | 22e. ADDRESS Lothian, Md 20820 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-12-81 | |
| 23c. NAME OF CEMETERY OR CREMATORY Christ Church | | 23d. LOCATION CITY OR TOWN COUNTY STATE West River, AA Co, Md | |
| 24. FUNERAL DIRECTOR NAME Hardesty FH.12 Ridgely Ave: Annapolis, Md. 21401 | | 25a. DATE REC'D. BY REGISTRAR JAN 13 1981 | |

REGISTRAR'S SIGNATURE **Hardesty FH.12 Ridgely Ave: Annapolis, Md. 21401**

U.S. DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D.C. 20250

TO: Mr. William D. ...
FROM: Mr. ...
SUBJECT: ...

Enclosed for Mr. ...

Very truly yours,
[Signature]

Charles H. ...
[Signature]

cc: Mr. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be evaluated within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8

REG. NO.

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6

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MADELINE M. O'CONNELL | | 2a. DATE OF DEATH MONTH DAY YEAR 1/27/81 | | 2b. HOUR 1:15 PM | |
| 3. SEX FEMALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 5 20 97 | |
| 6. BIRTHPLACE STATE OR FOREIGN COUNTRY MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE STATE OR FOREIGN COUNTRY MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH AA Co. MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION HAMMONDS LAKE NURSING | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BUREAU OF REC. | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD | | 13a. CITY OR TOWN BALTIMORE | | 13b. STREET ADDRESS 1309 W. Northern Pkwy | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas John O'Connell | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flora M. Neckerman | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | |
| 16b. SOCIAL SECURITY NO 219012135 | | 17. INFORMANT Mrs. J.P. Neckerman - phone | | 18. ADDRESS | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest. 4592 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular disease. DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-7-78 , 19 78 , to 1-27 , 19 81 , that (I) (we) last saw the deceased alive on 1-27 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Seenivasan | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-27-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Seenivasan | | 22e. ADDRESS 606 Hammonds Lane, BALTO, Md, 21225 | | | | | |

| | | | | | | | |
|---|--|--------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 1/28/81 | | 23c. NAME OF CEMETERY OR CREMATORY Westover Crem | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD | |
| 24. FUNERAL DIRECTOR NAME Robert A. Burman | | ADDRESS Severna Park | | 25. DATE REC'D. BY REGISTRAR FEB 2 1981 | | | |

6-10-00

10/10/00

10/10/00

10/10/00



10/10/00



REG. NO.

| | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|------------------------------------|--|--|--|--------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| MICHAEL C. O'CONNOR | | | | | | 1-16-81 | | 21 | | 00 | | 00 | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 24 HRS | | 24 HRS | |
| MALE | | W | | 12 16 80 | | 70 | | MONTHS | | DAYS | | HOURS | | MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| LA | | USA | | | | Cume Arundel Co | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Annapolis | | Anne Arundel Gen Hosp | | RADM, USN (Ret) | | USN | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | |
| MD | | AA CO | | Annapolis | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 3 ARLIE DR | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| MICHAEL | | O'CONNOR | | yes | | 27-59 | | 439-56-8766 | | NRMCLinic, Annapolis, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF (b) | | DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 4100 | | Cardiac Arrest | | Myocardial Infarction | | ASCVD | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | with hypoglycemia | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| N/A | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | N/A | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | STREET | | N/A | | | | | | | | | |
| 22a. I certify that (I) <input checked="" type="checkbox"/> this hospital attended the deceased from 1/16, 1981, to 1/16, 1981, that (I) (we) last saw the deceased alive on 1/16, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | | | |
| | | James F. Ervin | | | | | | 19 Jan 81 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | | |
| JAMES F. ERVIN, CAPT, MC, USN | | Director of Clinical Services | | | | | | | | | | | | | |
| | | NRMCLinic, Annapolis, Md. 21502 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. REGISTRAR'S SIGNATURE | | | | | | | |
| Burial | | 1/21/81 | | USNAVAL VADERS | | Annapolis, MD | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | 24a. NAME | | 24b. ADDRESS | | | | | | | | | | | |
| | | John M. Layton | | Annapolis, Md. | | | | | | | | | | | |

U.S. 1

1-16-81

Michael C. Cannon

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 0 0 2 1 8 | | | |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| FIRST MIDDLE LAST Carol Sue Oertel | | | | MONTH DAY YEAR Jan 21, 1981 | | | | 315 PM | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 28 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oklahoma | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1426 Catlyn Place | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. A.A. Annapolis | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1426 Catlyn Place | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unk | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unk | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. — | | 17. INFORMANT ADDRESS E. James Oertel # 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 1579 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Adenocarcinoma of</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pancreas</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 75, to 21 Jan, 19 81, that (I) (we) last saw the deceased alive on 20 Jan 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the cause(s) stated above. (If we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Jon B. Lowe | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 21 Jan 81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jon B. Lowe | | | | 22e. ADDRESS 121 CATHEDRAL ST. Annapolis, Md. | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/24/81 | | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME John M. Sayler + Sons | | | | ADDRESS Annapolis, Md. | | | | 25. DATE REC'D BY REGISTRAR 26. REGISTRAR'S SIGNATURE | | | |

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 00219 | |
|---|---------------------|--|---|---|--------------------------------|---|---------------|---|--|---|--|
| 1. STATE REGISTRAR <i>Middle</i> | | 1. DECEASED NAME (TYPE OR PRINT) <i>Floyd John Offer</i> | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 14 1981 2b. HOUR 6 AM | |
| 3. SEX <i>M</i> | 4. RACE <i>2</i> | 5. DATE OF BIRTH MONTH DAY YEAR 6 30 1981 | 6. AGE (IN YEARS LAST BIRTHDAY) <i>84</i> YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 14 1981 | 7d. HOUR 6 AM | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ann Arundel General</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 10. CITY OR TOWN OF DEATH <i>Annapolis</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel General</i> | | | | 12c. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>MARYLAND A.A. CHURCHTON</i> | | | 13e. STREET ADDRESS <i>5387 Deal Churchton Road</i> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>CHARLES W. OFFER</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ELLA CHEW</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i> | | | | 16b. SOCIAL SECURITY NO. <i>217-18-6865</i> | | 17. INFORMANT ADDRESS <i>JAMES OFFER 721 Oak La. Churchton, Md.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Atherosclerosis</i> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i> | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Chandra</i> | | TITLE (SPECIFY) <i>Depo 49</i> | | M.D. <i>Depo 49</i> | | MEDICAL EXAMINER | | DATE SIGNED <i>1.14.81</i> | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>E. L. H. H. H.</i> | | ADDRESS <i>Annapolis, Md</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | 23b. DATE <i>1-17-1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>OFFER CEMETERY</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>CHURCHTON A.A. MARYLAND</i> | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 16 1981</i> | | | |
| 24. FUNERAL DIRECTOR NAME <i>WILLIAM REESE & SONS MORTUARY, P.A.</i> | | ADDRESS | | 25b. REGISTRAR'S SIGNATURE <i>Deputy Registrar</i> | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

BP

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 00220

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|---|--|--|---|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) Elsie E. Oliff | | | 2a DATE OF DEATH MONTH DAY YEAR Jan 4 81 | | | 2b HOUR 8:30 P M | | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR Jan 2 93 | | 6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | | 7a IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7c CITIZEN OF WHAT COUNTRY? U.S. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | |
| 10 CITY OR TOWN OF DEATH Crownsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairfield Nursing Center | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Govt. Worker | | 12b KIND OF BUSINESS OR INDUSTRY Ret. | |
| 13a STATE MD. | | | 13b COUNTY Anne Arundel | | 13c CITY OR TOWN Annapolis | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Wm | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wm | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | |
| 16b SOCIAL SECURITY NO. 578-32-3381 | | | 17 INFORMANT C. R. Schantz | | | 18 ADDRESS 1519 CIRCLE DR ANNAPOLIS - MD. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Generalized hypoxemia DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immed year | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 19_____, that (I) (we) lost saw the deceased alive on 19_____, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE Weintraub M.D. | | | | | | 22c DEGREE M.D. | | 22d DATE SIGNED Jan 4, 1981 | |
| 22e PHYSICIAN'S NAME (TYPE OR PRINT) Weintraub M.D. | | | | | | 22f ADDRESS 104 Forbes St. Annapolis, MD | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | | 23b DATE 6/6/81 | | 23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln | | 23d LOCATION CITY OR TOWN COUNTY STATE Greentown P.G. MD. | | |
| 24 FUNERAL DIRECTOR John M. Sykes | | | | | | 24b ADDRESS Chesapeake, MD | | 25a DATE JAN 12 1981 | |



JAN 5 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8100221 | | E.S.T. | | | | | | | | |
|---|--|------------------------------|--|--|---|--|------------------------------------|--|--|--|-----------------|--|-----------------------------------|---|------------------|---------------------|--|--|------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | FIRST MIDDLE LAST | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR A.M. | | | | | | |
| GEORGE | | | | | LEWIS | | | | | ORD | | | | | JANUARY 27, 1981 | | | | 2:39 | |
| 3. SEX | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | |
| MALE | | WHITE | | | MONTH DAY YEAR Oct. 18, 1915 | | | 65 YRS. | | | MONTHS DAYS | | HOURS MIN. | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | |
| W. Virginia | | U.S.A. | | | | | | ANNE ARUNDEL COUNTY MD. | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| GLEN BURNIE | | | | | NORTH ARUNDEL HOSPITAL | | | | | Plant Sup. | | | Fed. Yeast | | | | | | | |
| 13a. STATE | | | | | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | |
| Maryland | | | | | | | | | | A.A. | | Glen Burnie | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 319 Orchard Road | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | | FIRST MIDDLE LAST | | | | | | | | | | | | | | | |
| Walter R. Ord | | | | | May C. Helton | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT (Wife) | | | ADDRESS | | Same as # 13 | | | | | | | | |
| No | | | | | N/A | | 235.09.7612 | | | Mrs. Norene S. Ord | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Cardiac Arrhythmia of shock</i> | | | | | | | | | | | | | | | | | | | | |
| 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Damage</i> | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>ABSD</i> | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>COPD, Hypertension</i> | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 19c. AUTOPSY | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | |
| | | | | | P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION | | | | | | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | | | | CITY OR TOWN COUNTY STATE | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/27/81 to 1/27/81, that (I) (we) lost saw the deceased alive on 1/27/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | |
| 23a. SIGNATURE | | | | | | | | | | DEGREE | | 23c. DATE SIGNED | | | | | | | | |
| ANASTACIO E. SUBONG, M.D. | | | | | | | | | | | | 1/27/81 | | | | | | | | |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 23e. ADDRESS | | | | | | | | | | | | | | | |
| | | | | | 7951 OAKWOOD ROAD GLEN BURNIE, MARYLAND 21061 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | | | | | | | | |
| Burial | | | | | 30 JAN 81 | | Glen Haven Mem. Pk. | | | Glen Burnie A.A., Md. | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | |
| Singleton Funeral Home Maryland | | | | | JAN 30 1981 | | | | | <i>Robert H. H. H.</i> | | | | | | | | | | |

BP

JANUARY 27, 1981 9:39

DR

LEWIS

GEORGE

ANN ARUNDEL COUNTY

ANN ARUNDEL HOSPITAL

GLENN BURKE

GLENN BURKE, 11111
11111 ANN ARUNDEL ROAD

ANN ARUNDEL HOSPITAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas Parker | | 2a. DATE OF DEATH MONTH DAY YEAR 1 22 81 | | 2b. HOUR 12 05 M | |
| 3 SEX MALE | | 4 RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 12 16 10 | |
| 6a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 6 AGE (IN YEARS LAST BIRTHDAY) 69 70 YRS. | |
| 10 CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General | | 9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel COUNTY MD. | |
| 13a STATE MARYLAND | | 13b COUNTY A.A. | | 13c CITY OR TOWN ANNAPOLIS | |
| 14 FATHER'S NAME FIRST MIDDLE LAST GEORGE W. PARKER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY E. BLAKE | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. 219-01-0603A | | 17. INFORMANT ADDRESS Annapolis, Md. 2045 Parker Dr. | |

| | | |
|---|--|---|
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach & Intestines to the Lungs & Liver 1519 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos approx |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 9 , 19 80 , to Jan 22 , 19 81 that (I) (we) last saw the deceased alive on Jan 22 , 19 81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Jay W. Allen | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jay W. Allen | | | | 22e. ADDRESS 111 Cathedral St Annapolis Md | | | |

| | | | | | | | |
|--|--|-------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1-24-1981 | | 23c. NAME OF CEMETERY OR CREMATORY PINELAWN MEM. PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland | |
| 24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 26 1981 | | 25b. REGISTRAR'S SIGNATURE B. J. McCurdy | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8100223 | | | | | |
|--|--|---|--|---|--|---|--|---|--|--|--|---|--|----------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | |
| 1. DECEASED NAME FIRST MIDDLE LAST Shirley Rae PARKINSON | | | | | | | | | | Jan 2 1981 | | | | 1145 PM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 9, 1936 | | 6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH A.A. Co. MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A-A-G. H. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN MD A.A. Annapolis | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 935 Boucher Avenue | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Drury | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Catlin | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | 16b. SOCIAL SECURITY NO. #13a | | 17. INFORMANT ADDRESS George H. Parkinson Same as #13a | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 1809 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Uterine Compression</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Carcinoma of Cervix</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 15, 1980, to Jan 2, 1981, that (I) (we) last saw the deceased alive on Jan 2, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Michael B. Monias | | | | DEGREE MD | | | | 22c. DATE SIGNED Jan 2 1981 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael B. Monias MD | | | | 22e. ADDRESS 121 Cathedral St., Annapolis, MD | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan 6, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD | | 23e. DATE REC'D BY REGISTRAR IN REGISTER'S SIGNATURE JAN 7 1981 | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS John M Taylor & Sons, Annapolis, MD | | | | | | | | | | | | | | | |

1. The first part of the document is a letter from the President of the United States to the Congress, dated September 17, 1787. It is a very important document, as it is the first official communication from the President to the Congress. The letter is written in a very formal and dignified style, and it is signed by George Washington.

2. The second part of the document is a report from the Secretary of the Navy, dated September 17, 1787. It is a very important document, as it is the first official communication from the Secretary of the Navy to the Congress. The report is written in a very formal and dignified style, and it is signed by John Jay.

3. The third part of the document is a report from the Secretary of the Treasury, dated September 17, 1787. It is a very important document, as it is the first official communication from the Secretary of the Treasury to the Congress. The report is written in a very formal and dignified style, and it is signed by Alexander Hamilton.

4. The fourth part of the document is a report from the Secretary of the War, dated September 17, 1787. It is a very important document, as it is the first official communication from the Secretary of the War to the Congress. The report is written in a very formal and dignified style, and it is signed by Henry Knox.

5. The fifth part of the document is a report from the Secretary of the State, dated September 17, 1787. It is a very important document, as it is the first official communication from the Secretary of the State to the Congress. The report is written in a very formal and dignified style, and it is signed by Thomas Jefferson.

6. The sixth part of the document is a report from the Secretary of the Interior, dated September 17, 1787. It is a very important document, as it is the first official communication from the Secretary of the Interior to the Congress. The report is written in a very formal and dignified style, and it is signed by James Osgood.

7. The seventh part of the document is a report from the Secretary of the Education, dated September 17, 1787. It is a very important document, as it is the first official communication from the Secretary of the Education to the Congress. The report is written in a very formal and dignified style, and it is signed by John Jay.

8. The eighth part of the document is a report from the Secretary of the Agriculture, dated September 17, 1787. It is a very important document, as it is the first official communication from the Secretary of the Agriculture to the Congress. The report is written in a very formal and dignified style, and it is signed by James Osgood.

9. The ninth part of the document is a report from the Secretary of the Commerce, dated September 17, 1787. It is a very important document, as it is the first official communication from the Secretary of the Commerce to the Congress. The report is written in a very formal and dignified style, and it is signed by John Jay.

10. The tenth part of the document is a report from the Secretary of the Marine, dated September 17, 1787. It is a very important document, as it is the first official communication from the Secretary of the Marine to the Congress. The report is written in a very formal and dignified style, and it is signed by John Jay.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 0 2 2 4

REG. NO.

| | | | | | | |
|---|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ALLEN LESTER PATTEN JR | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 3, 1981 | | 2b. HOUR 8:59 PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 12, 1935 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS. | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | |
| 13a. STATE Maine | | 13b. COUNTY Kennebec | | 13c. CITY OR TOWN Augusta | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Allen Lester Patten Sr | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gladys Pearl Frost | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | 16b. SOCIAL SECURITY NO. 007-30-4187 | | 17. INFORMANT ADDRESS Plummer Funeral Home Augusta, Me. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 4274 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 3 , 19 81 , to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Charles Wu | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-4-81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. CHARLES WU | | 22e. ADDRESS 7845 OAKWOOD ROAD GLEN BURNIE, MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/6/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Kling Cemetery | | |
| 24. FUNERAL DIRECTOR NAME Raymond C. Fink | | ADDRESS Glen Burnie, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 7 1981 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE Patricia McCreedy | | |

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 0 2 2 5

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|---|---|--|--------------------------------------|-----------------------------------|-----------------|-------|-----------------|------|----------|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| James Earle Paxton, Jr. | | | | | 1/21/81 | | | | | 8 p M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Male | White | 7/10/22 | | 58 | | MONTHS | | DAYS | | HOURS |
| 7a. BIRTHPLACE COUNTRY | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Md. | USA | | | Anne Arundel County MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Annapolis | Anne Arundel General Hospital | | US Govt. | | Civil Service | | | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | | | | | | |
| Md | | A.A. | | 94 TARRAGON LA. | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| James C. Paxton | | Myrtle Lewis | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | |
| Yes | | WWII | | Cecilia Joan Paxton | | #13 | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma

1991

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 year

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

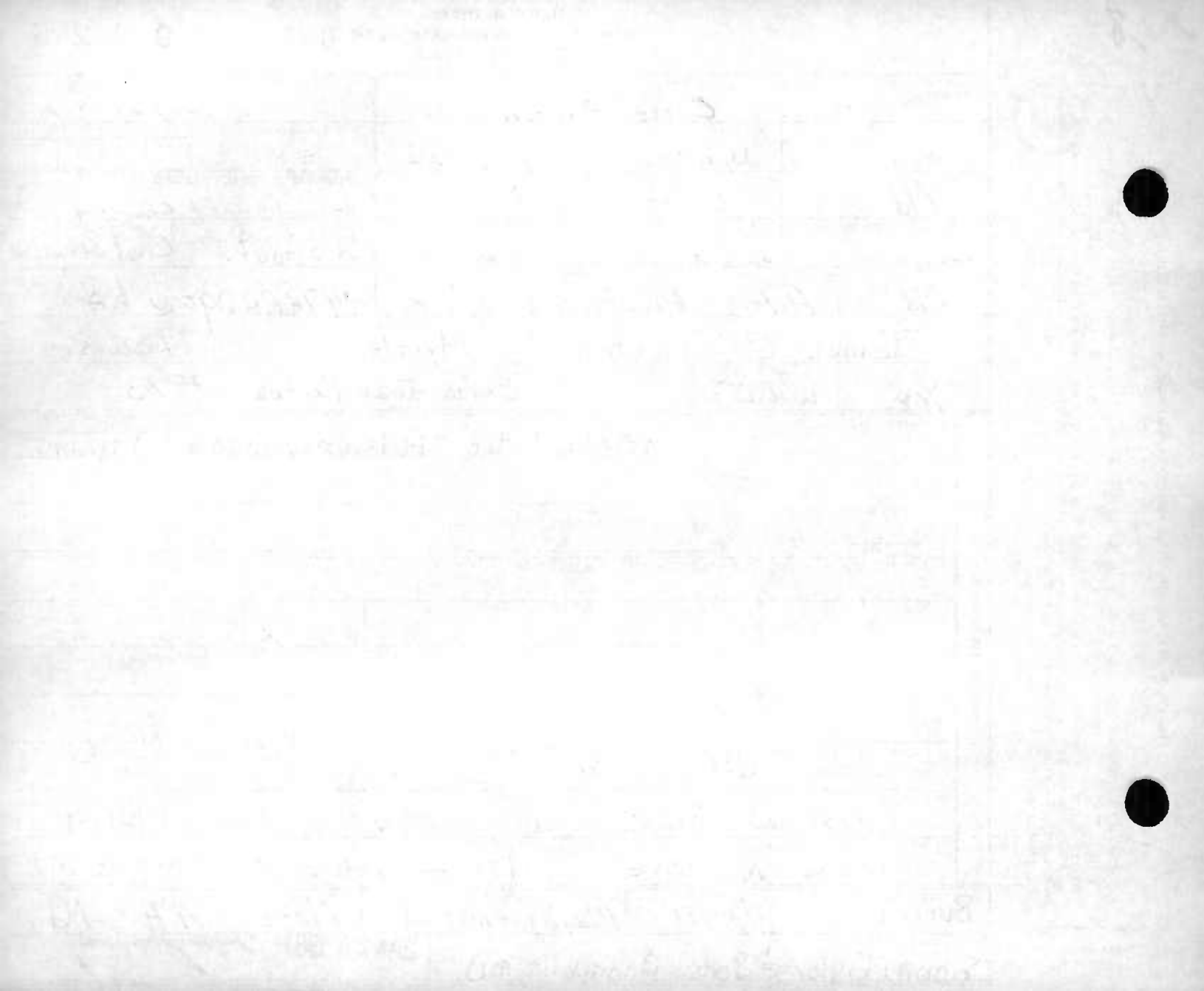
| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/28 1980, to 1/21 1981, that (I) (we) lost saw the deceased alive on 1/21 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Emser W. Cole | | 22c. DATE SIGNED 1/21/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ENSER W. COLE | | 22e. ADDRESS 121 CATHEDRAL ST ANNAP MD. | |

| | | | |
|--|-----------|------------------------------------|-------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN |
| Burial | 1/24/81 | Mayo Memorial | MAYO A.A. MD. |
| 24. FUNERAL DIRECTOR NAME | | 25a. OTHER REGISTRAR NAME | |
| John M. Taylor & Sons - Annapolis, MD | | JAN 25 1981 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 0 0 2 2 6 | | | |
|--|---|--|---|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2. DATE OF DEATH | | | 3. HOUR | |
| FIRST MIDDLE LAST Marlin J. Phelps | | | MONTH DAY YEAR 1 2 81 | | | P M 10 A | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Male | White | MONTH DAY YEAR 11 18 30 | | 50 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | U.S. | | | Anne Arundel Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Annapolis | Anne Arundel Gen. | | | Mechanist | | Mfg. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE | | | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | |
| Md. | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1077 Dicus Mill Rd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | |
| Jasper Phelps | | | Osa Unknown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| No | | | 888-18-8215 | | Larry M. Phelps - Arnold MD 21012 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRACEREBRAL Hemorrhage</u> <u>4310</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 1</u> 19 <u>81</u> to <u>JAN 2</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>JAN 2</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Jack Kushner</u> | | | | DEGREE MD | | 22c. DATE SIGNED 1/3/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jack Kushner</u> | | | | 22e. ADDRESS <u>20 Ridgely - Annapolis, MD.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 1-5-81 | | Glen Haven Cem. | | Glen Burnie Md. 21062 | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Robert S. Barranco | | | | 501 R. Ritchie Hwy Severna Park | | JAN 1 1981 | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. 71 00227 | | | | |
|---|--|--|--|--|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Harrison MATTHEW Price | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 21 81 | | | | |
| 3. SEX MALE | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 07 08 03 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | 2b. HOUR 10 45 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A.A. Gen. Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Elevator Operator | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN ANNAPOLIS | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1900 Vincent | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Washington Price | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgianna Johnson | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR YEARS) NO | | 16b. SOCIAL SECURITY NO. 214-05-0803 | | 17. INFORMANT ADDRESS LuBENIA B. Price Same As 13 E | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HISTOCYTIC LYMPHOMA 2000 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/30/80 , 19____, to 1/21/81 , 19____, that (I) (we) last saw the deceased alive on 1/21/81 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Stanley P. Watkins DEGREE | | | | | 22c. DATE SIGNED 1/21/81 | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY P. WATKINS | |
| 22e. ADDRESS 121 Cathedral - Annapolis - Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1-26-81 | | 23c. NAME OF CEMETERY OR CREMATORY PINE LAWN | | 23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS A.A. Md | | | |
| 24. FUNERAL DIRECTOR NAME C. E. Hicks III ADDRESS Annapolis - Md. | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 27 1981 | | 25b. REGISTRAR'S SIGNATURE Robert M. ... | | |

BP

Handwritten notes on lined paper, including the words "MAY 1964" and "RECEIVED".

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
8 1 0 0 2 2 8
CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 1. FOR STATE REGISTRAR EDGAR LEE RANCK | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEE E. RANCK | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 3, 81 | |
| 3 SEX male | | 4 RACE white | |
| 5. DATE OF BIRTH MONTH DAY YEAR OCT. 15, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | |
| 10 CITY OR TOWN OF DEATH CROFTON, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CROFTON Convalescent Ctr | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Work | | 12b. KIND OF BUSINESS OR INDUSTRY Civil Ser. | |
| 13a. STATE Md. | | 13b. COUNTY A.A. | |
| 13c. CITY OR TOWN Odenton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS 608 Rita Dr. | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Edgar LEWIS RANCK | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Lees | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 224.58.5884 | |
| 17. INFORMANT (Daughter) ADDRESS Mrs. Marjorie Ratcliffe | | Same as # 13 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Left ventricular failure</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular accident</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>months</u> <u>years</u> <u>years</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1/10 80 1/3 81 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/3</u> 19 <u>81</u> , to <u>1/3</u> 19 <u>81</u> , that (I) (we) lost <u>saw the deceased alive on</u> <u>above</u> , (I) (we) did (did not) <u>view the body after death</u> . | | | |
| 22b. SIGNATURE <u>Michael</u> | | DEGREE <u>MD</u> | |
| 22c. DATE SIGNED 1/3/81 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAX C FRANK MD | | 22e. ADDRESS 7575 Rutledge Hwy - Glen Burnie, Md 21061 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6 Jan. 81 | |
| 23c. NAME OF CEMETERY OR CREMATORY National Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Va. | |
| 24 FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME | | 25a. DATE REC'D. BY REGISTRAR JAN 5 1981 | |
| 25b. REGISTRAR'S SIGNATURE <u>Rita K. Brady</u> | | | |

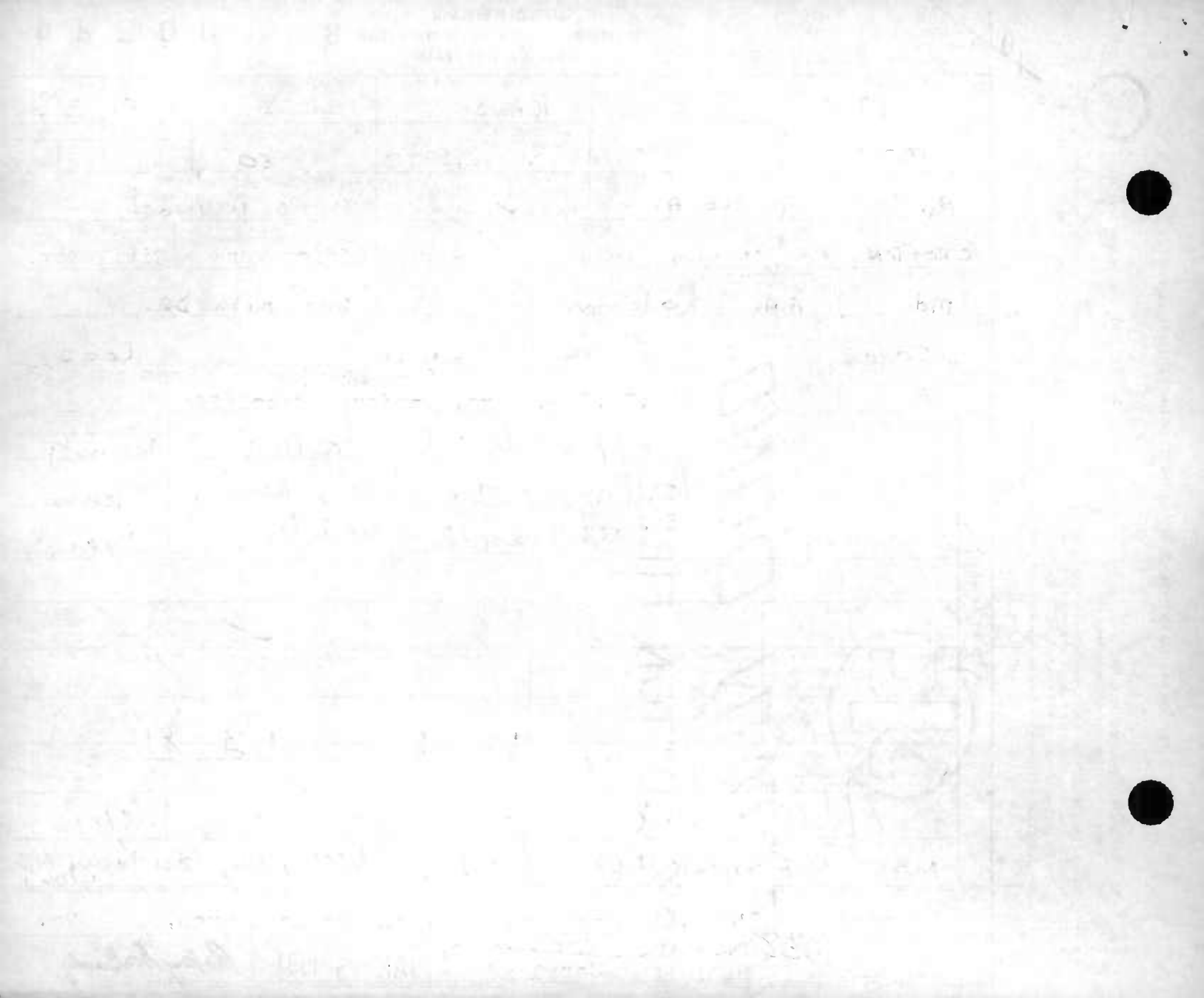
MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



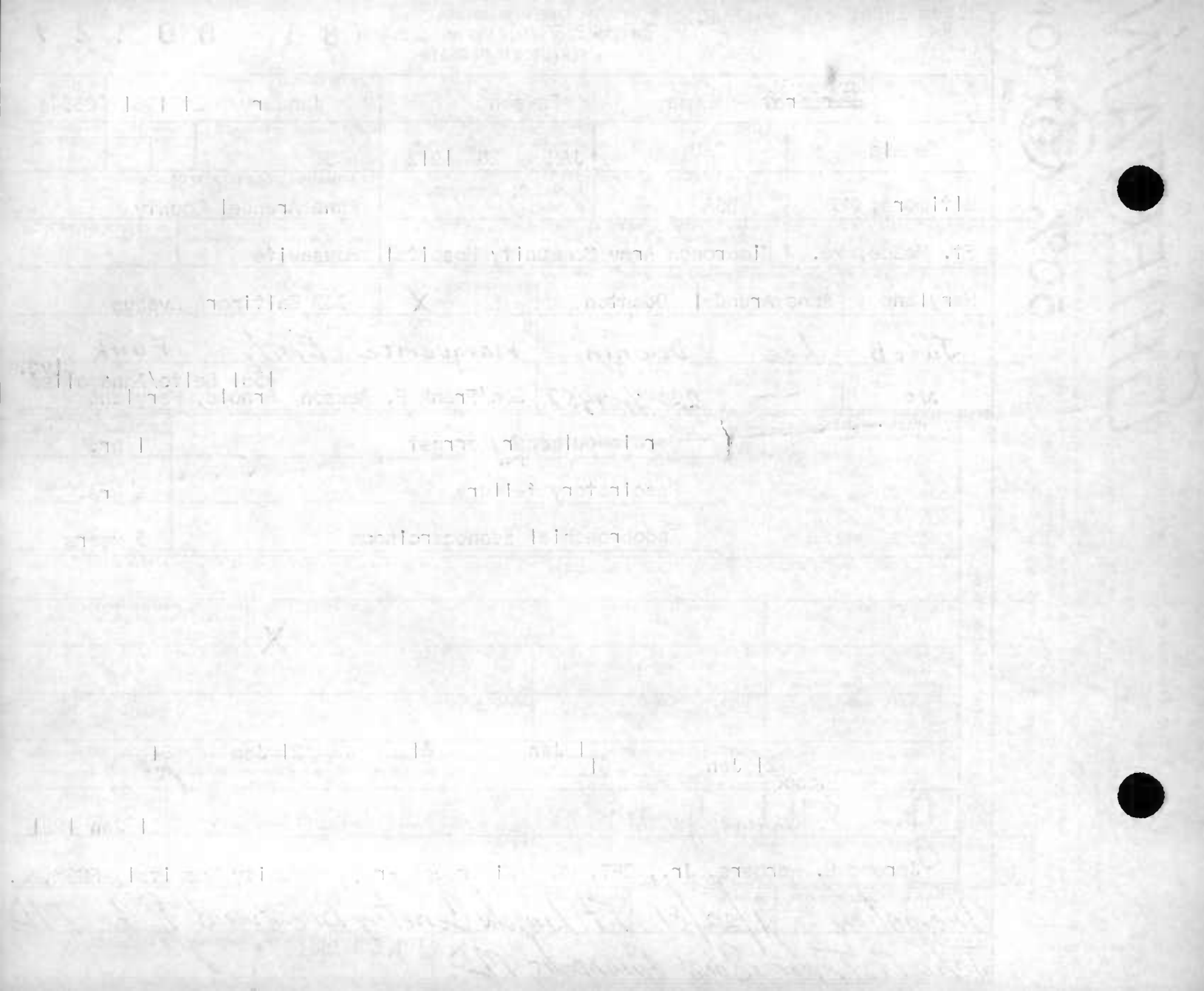
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| | | | | | | | | | | |
|---|--|--|---|---|--|--|--|---|--|--|
| Item 1 Per call with F.H. 1/23/81 FOR REGISTRAR DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 8100229 | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) MARGUERITE MARGARET Emma Rawson | | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 21 1981 | | | 2b. HOUR 0854a M | | |
| 3. SEX Female | | 4. RACE CAU | | 5. DATE OF BIRTH MONTH DAY YEAR JAN 28 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD. | | | | |
| 10. CITY OR TOWN OF DEATH Ft. Meade, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kimbrough Army Community Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | | | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Odenton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jacob Lee Downin | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marguerite Emily Funk | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | 16b. SOCIAL SECURITY NO. 220-36-9457 | | 17. INFORMANT ADDRESS Son/Frank F. Rawson 1551 Balto/Annapolis Blvd. Arnold, Maryland | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Respiratory failure (c) Endobronchial adenocarcinoma | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 2 hrs. 3 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 21 Jan 1981, to 21 Jan 1981, that (I) (we) lost the deceased alive on 21 Jan 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Jerome E. Herbers, Jr. MD | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 21 Jan 1981 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jerome E. Herbers, Jr., CPT, MC | | | | | 22e. ADDRESS Kimbrough Army Community Hospital, FEGM, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 1/22/81 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Brentwood P.C. MD | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME John M. Taylor & Sons Annapolis MD | | | | | 25. DATE RECEIVED BY REGISTRAR REGISTRAR'S SIGNATURE JAN 25 1981 | | | | | |



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81

00230

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Walter James Reed | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-24-81 | | | 2b. HOUR MIN. 12:30 M. | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 9-01-06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD. | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance (RET) | | 12b. KIND OF BUSINESS OR INDUSTRY Western Elec. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Millersville | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Wunder | | | 13e. STREET ADDRESS 499 Brampton Court | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT ADDRESS Same as # 13 | | Mrs. Lois M. Fowler (DAUGHTER) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4479 IMMEDIATE CAUSE (a) Fracture of leg with Sepsis | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk. | |
| DUETO, OR AS A CONSEQUENCE OF (b) Generalized arterial calcification | | | | | | | | | |
| DUETO, OR AS A CONSEQUENCE OF (c) Chronic Brain Syndrome | | | | | | | | grs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the physician) attended the deceased from Jan 24 , 19 81 , to Jan 24 , 19 81 , that (I) (we) saw the deceased alive on 24 Jan , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Gary M. Richardson, M.D. | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-25-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY M. Richardson, MD | | | | | | 22e. ADDRESS 104 Forbes Street Annapolis, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 27 JAN '81 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Park A.A. Md. | | |
| 24. FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME, GLEN BURNIE, MD | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 21 1981 | | 25b. REGISTRAR'S SIGNATURE Rafael McBratney | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8100231

REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Reese | | 2a. DATE OF DEATH MONTH DAY YEAR 1-21-81 | | 2b. HOUR 7:50^{AM} | |
| 3. SEX M | | 4. RACE 2 | | 5. DATE OF BIRTH MONTH DAY YEAR 2 6 79 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ALABAMA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN ANNAPOLIS | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 108 W. Washington Street | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM REESE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH HUNTER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. 232-07-7488A | | 17. INFORMANT ADDRESS WILLIAM REESE, II 812 West St. Annapolis, Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 3979 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) Voluntary Heart Disease, Rheumatism DUE TO, OR AS A CONSEQUENCE OF (c) Circulation of blood PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 29 Dec , 19 80 , to 21 Jan , 19 81 , that (I) (we) lost saw the deceased alive on 30 Jan , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Don B. Lowe | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 21 Jan 81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Don B. Lowe | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1-27-1981 | | 23c. NAME OF CEMETERY OR CREMATORY HILL CREST CEMETERY | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland | | 25a. DATE REC'D. BY REGISTRAR JAN 26 1981 | | | |
| 24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A. | | 25b. REGISTRAR'S SIGNATURE Robert Meluskey | | | |

MEDICAL CERTIFICATION

99

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Population may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy requested.

BP



MAILED

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|----------|----------------------------------|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| FIRST MIDDLE LAST <i>Dorothy W. Rennie</i> | | | MONTH DAY YEAR <i>1-25-81</i> | | | 3:45 M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | |
| <i>F</i> | <i>W</i> | MONTH DAY YEAR <i>9-16-06</i> | <i>74</i> | | | MONTHS DAYS HOURS MIN. | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7c. CITIZEN OF WHAT COUNTRY? | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| <i>Maryland</i> | | | <i>USA</i> | | | <i>Anne Arundel County</i> MD. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION | | |
| <i>A.A. Co.</i> | | | <i>Anne Arundel General Hospital</i> | | | <i>Homemaker</i> | | |
| 13a. STATE | | | 13b. CITY OR TOWN | | | 13c. STREET ADDRESS | | |
| <i>Maryland</i> | | | <i>Baltimore</i> | | | <i>804 E. Lake Avenue</i> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. KIND OF BUSINESS OR INDUSTRY | | |
| FIRST MIDDLE LAST <i>Thomas E. Watts</i> | | | FIRST MIDDLE LAST <i>Rosa Ball</i> | | | <i>Own Home</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No.</i> | | | <i>216 52 5792</i> | | | <i>Mrs. Rosemary E. Morris, Annapolis, Md.</i> | | |

| | | | | | |
|---|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY: | | | <i>Sudden</i> | | |
| IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) <i>COPD</i> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| <i>Dehydration</i> | | | | | |

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2) | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | STREET CITY OR TOWN COUNTY STATE | | | | | |

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 22a. I certify that (this hospital) attended the deceased from <i>1/24</i> 19 <i>81</i> to <i>1/25</i> 19 <i>81</i> , that (we) lost saw the deceased alive on <i>1/25</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|

| | | | | | | | | |
|----------------|--|--|-----------|--|--|------------------|--|--|
| 22b. SIGNATURE | | | DEGREE | | | 22c. DATE SIGNED | | |
| <i>MD</i> | | | <i>MD</i> | | | <i>1/25/81</i> | | |

| | | | | | |
|---------------------------------------|--|--|---|--|--|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | |
| <i>David Krims M.D.</i> | | | <i>Anne Arundel General Hospital, Md.</i> | | |

| | | | | | | | | | | | |
|---------------------------------|--|--|----------------|--|--|------------------------------------|--|--|--------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | |
| <i>Burial</i> | | | <i>1/27/81</i> | | | <i>New Cathedral</i> | | | <i>Balto., Md.</i> | | |

| | | | | | | | | |
|--|--|--|-------------------------------|--|--|----------------------------|--|--|
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| <i>Henry W. Jenkins & Sons Co.</i> | | | <i>JAN 28 1981</i> | | | <i>Rosemary Morris</i> | | |

| | | | | | | | | |
|--|--|--|-------------------------------|--|--|----------------------------|--|--|
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
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| | | | | | | | | |
|--|--|--|-------------------------------|--|--|----------------------------|--|--|
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
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|--|--|--|-------------------------------|--|--|----------------------------|--|--|
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
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| | | | | | | | | |
|--|--|--|-------------------------------|--|--|----------------------------|--|--|
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| <i>Henry W. Jenkins & Sons Co.</i> | | | <i>JAN 28 1981</i> | | | <i>Rosemary Morris</i> | | |

| | | | | | | | | |
|--|--|--|-------------------------------|--|--|----------------------------|--|--|
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| <i>Henry W. Jenkins & Sons Co.</i> | | | <i>JAN 28 1981</i> | | | <i>Rosemary Morris</i> | | |

Burial 1127/81 New Cathedral Baltimore, Md.
 Henry W. Jenkins & Son Co.
 4006 York Road Baltimore, Md. 21212

No. 210 52 5792 Mrs. Rosemary E. Norris, Annapolis, Md.

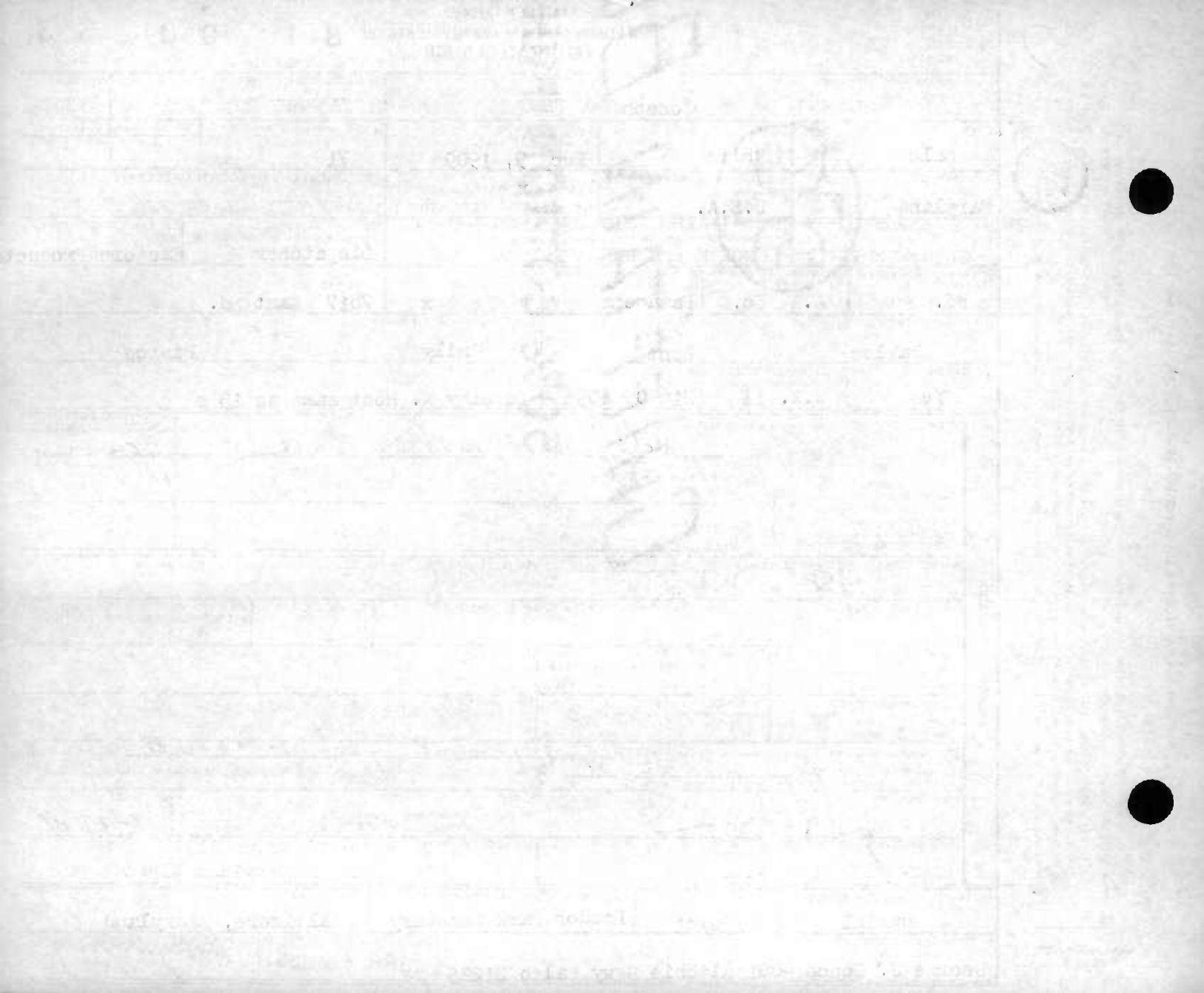
Thomas E. White Rose Hill
 Maryland Baltimore X 804 E. Lomb Avenue
 A.A. Co. Anne Arundel General Hospital Homewood, Md.
 Maryland Anne Arundel County

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8100233 | | EST | |
|--|--|--|--|---|--|--|---|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEMUEL Joseph RENT | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 22, 1981 | | 2b. HOUR 9:30 P M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec 9, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS MIN 71 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dispatcher | | 12b. KIND OF BUSINESS OR INDUSTRY Eastern Product | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | | 13b. COUNTY A.A. Co. | | 13c. CITY OR TOWN Pasadena | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Rent | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Pierce | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II | | 17. INFORMANT ADDRESS Dorothy M. Rent same as 13 e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1729 Malignant melanoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Acc id | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-19-81 , to 1-22-81 , that (I) (we) lost saw the deceased alive on 1-22-81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-23-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JACK I. STERN, M.D. | | 22e. ADDRESS 300 Hospital Drive #135 Glen Burnie, Maryland 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/26/81 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR NAME George J. Gonce | | | | ADDRESS 4001 Ritchie Hwy Balto 21225 | | 25a. DATE REC'D. BY REGISTRAR JAN 26 1981 | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | |

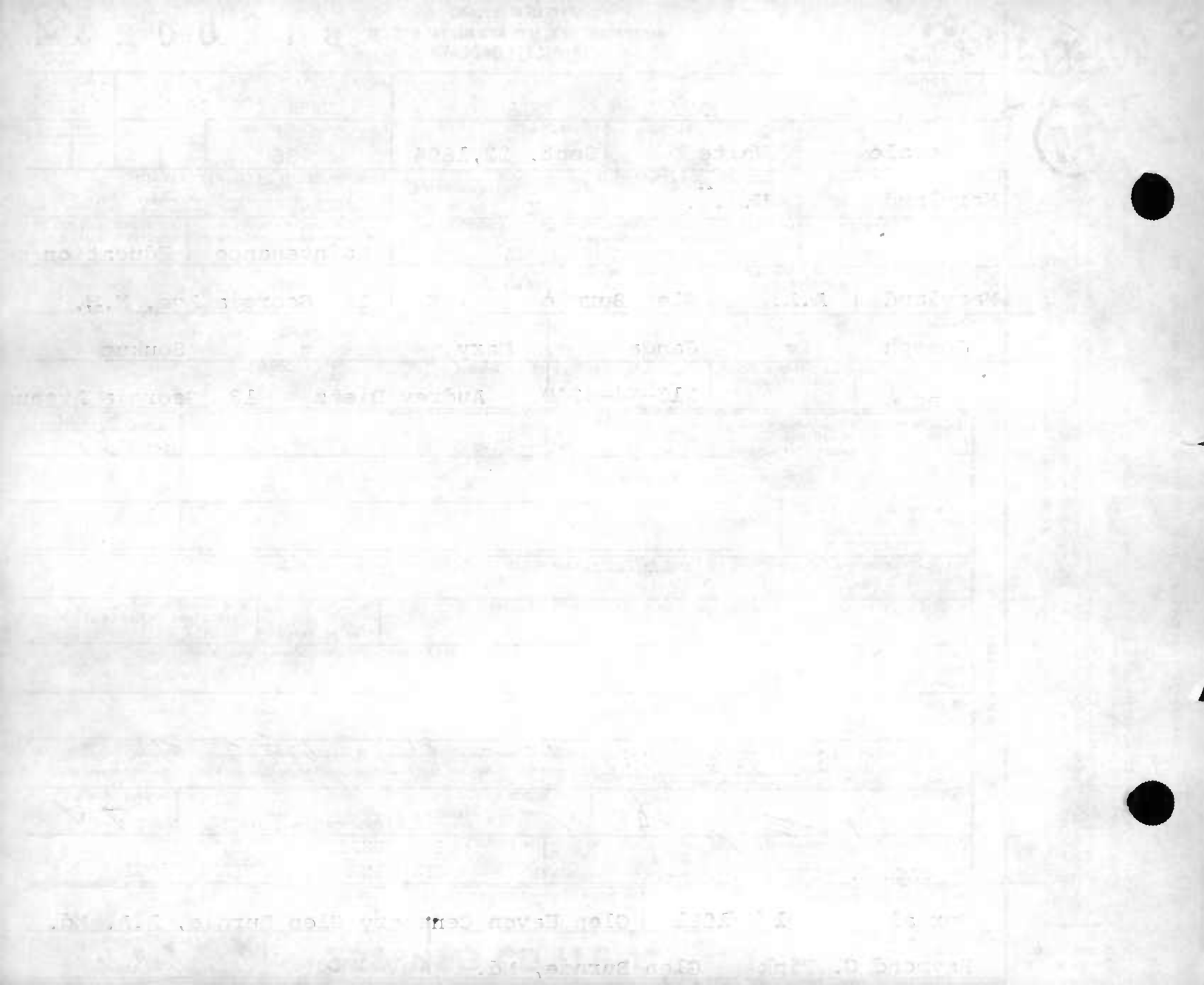


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 0 0 2 3 4 REG. NO. EDT | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA MARY REZAC | | | | JANUARY 6, 1981 | | | | 1:50P M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 22, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 86 YRS. | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance | | 12b. KIND OF BUSINESS OR INDUSTRY Education | |
| 13a. STATE Maryland | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 20 Georgia Ave. N.W. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph = Janda | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary = Soukup | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO 213-74-5240 | | 17. INFORMANT ADDRESS Audrey Dietz 13 Georgia Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>C.V.A.</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-2-1981 to 1-6-1981, that (I) (we) last saw the deceased alive on 1-6-1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> DEGREE _____ | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1-7-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JACK I. STERN, M.D. | | | | 22e. ADDRESS 300 HOSPITAL DRIVE, #135 GLEN BURNIE, MARYLAND 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/9/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A. Md. | | | |
| 24. FUNERAL DIRECTOR NAME Raymond C. Fink | | | | ADDRESS Glen Burnie, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 9 1981 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| ISABELLE S. Richards | | 1-7-81 | | 4:05 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Female | Caucasian | Apr. 2, 1896 | 84 | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Pennsylvania | USA | | Anne Arundel MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Annapolis | Anne Arundel General Hosp. | | Housewife | | |
| 13a. STATE | | 13b. CITY OR TOWN | 13c. STREET ADDRESS | | |
| Pa. | Johnston | 717 Wayne St. | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| John H. Scherrer | | Ann McGarvey | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| no | | 166-30-5394 | | Anne R. Leonard Bowie, Md. | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE | | | | | 4 mos |
| DUE TO, OR AS A CONSEQUENCE OF (b) ASCU | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| Renal Failure | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 1/5/81 to 1/8/81, that (1) (me) last saw the deceased alive on 1/5/81, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (1) (me) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| R. Biern | | | | 1/8/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Robert Biern MD | | 121 Cathedral St., Annapolis, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial-transit | | Jan 9 1981 | | Holy Sacrament Cem | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Beall Funeral Home | | JAN 12 1981 | | R. Biern | |

Death Funeral Home
 16000 Annapolis Rd.
 Bowie, Maryland
 Burial-Transit Jan 9 1981 Holy 2 Crematory Green Spring, P.
 Robert Blair MD
 121 C Street St., Annapolis, Md.

no
 166-38-5334 Anne R. Leonard Bowie, Md.
 John H. Schetter Ann
 2401 Belair Drive
 McDevay

P. Johnston x 317 Wayne St.

Annapolis Anne Arnold General Hosp. Housewife
 Pennsylvania USA x Anne Arnold

Form 10 C-1000 Jan 2, 1981 84

2. 1981-1-1 408

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 0 2 3 6
EST

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ROBERT WALKER RICHMOND | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 21, 1981 | | | 2b. HOUR 5:10A M | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 26, 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Skilled Labor | | 12b. KIND OF BUSINESS OR INDUSTRY Chevron Asp. | | |
| 13a. STATE Maryland | | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1237 Guilford Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Arthur S. Richmond | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Roberta Mitchell | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | 16b. SOCIAL SECURITY NO. W.W. II 213.12.7955 | | 17. INFORMANT (Wife) ADDRESS Mrs. Florence F. Richmond Same as # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MI 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) ASHD DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Old MI. Hypertension | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11.25.1980 to 11.25.1980 , that (I) (we) last saw the deceased alive on 11.25.1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE C. Dorkan | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-21-81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CENAP S. DORKAN, M.D. | | | 22e. ADDRESS 325 HOSPITAL DRIVE GLEN BURNIE, MARYLAND 21061 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 23 JAN. 81 | | 23c. NAME OF CEMETERY OR CREMATORY Security Process | | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balt., MD. | | | |
| 24. FUNERAL DIRECTOR NAME Singleton Funeral Home Maryland | | | 25a. DATE REC'D. BY REGISTRAR JAN 22 1981 | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 81 00237 | |
|---|---|---|--|--|------------------------------|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lucille May Riffle | | | 2a. DATE OF DEATH MONTH DAY YEAR Jan 5th 81 | | 2b. HOUR 7:30 P.M. |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR May 1st 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Ann ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH millersville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 300 GALENA ct. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife | |
| 13a. STATE md | | 13b. COUNTY ann arundel | 13c. CITY OR TOWN millersville | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jim Hagerson | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 302-18-6475 | | 17. INFORMANT ADDRESS Daughter - Mrs Edna Smith | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Acute Heart Failure 4292 DUE TO, OR AS A CONSEQUENCE OF (b). Cardio vascular Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c). Several years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 24 1980 to 1-5 1981 , that (I) (we) lost sdw the deceased above on Dec 24 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE N.B. Shah | | DEGREE MD | | 22c. DATE SIGNED Jan 5 1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) N.B. Shah MD | | 22e. ADDRESS P.O. 326 Gambrells, md 21054 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/8/81 | | 23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cem | |
| 23d. LOCATION CITY OR TOWN Columbia | | COUNTY Calvert | | STATE Md | |
| 24. FUNERAL DIRECTOR NAME Richard A. Benavente | | ADDRESS Severna Park Md | | 25a. DATED & REGD. BY REGISTRAR JAN 12 1981 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Robert McQuinn | |

BP

DHMH - 16 25M

(VR A 15 (4) 1/7/74)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 0 0 2 3 8 | |
|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | EST | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| DOROTHY B. RILEY | | | | JANUARY 18, 1981 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | |
| Female | | white | | Sept. 30, 1926 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| West Virginia | | U.S.A. | | 54 YRS. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | ANNE ARUNDEL COUNTY MD. | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Maryland | | A. A. | | Glen Burnie | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Orville = Andrews | | Nellie UNKNOWN | | Housewife | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | 236-32-7352 | | Paul B. Riley Same as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Cardio-respiratory failure. | | | | | |
| 5849 | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Acute Renal Failure | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Shock | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH XXXX RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Ischemic Bowel disease with rupture of small bowel. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOTWHILE <input type="checkbox"/> AT WORK | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION (STREET CITY OR TOWN COUNTY STATE) | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/3/81 19 to 1/18 1981 that (I) (we) last saw the deceased alive on 1/18/81 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE DEGREE | | 22c. DATE SIGNED | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (THE OFFICIAL) | |
| Jorge B. Ramirez, M.D. | | 1/19/81 | | 7845 Oakwood Road #205 Glen Burnie, Maryland 21061 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 1/21/81 | | Meadowridge Cem. | |
| 24. FUNERAL DIRECTOR (NAME) | | 24b. ADDRESS | | 24c. DATE REC'D. BY REGISTRAR | |
| Raymond C/ Fink | | Glen Burnie, Md. | | JAN 21 1981 | |

1930-1931

1931-1932

1932-1933

1933-1934

1934-1935

1935-1936

1936-1937

1937-1938

1938-1939

1939-1940

1940-1941

1941-1942

1942-1943

1943-1944

1944-1945

1945-1946

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 0 2 3 9 | |
|--|---|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | E.S.T. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LYDA BEATRICE RILEY | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 31, 1981 | | 2b. HOUR 2:45A_M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 6 14 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY Home |
| 13a. STATE Md. | | 13b. COUNTY Anne Arundel | 13c. CITY OR TOWN Severna Park | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 00-545-28-7702 | | 17. INFORMANT ADDRESS James J. Riley 162 Dundee Rd. Severna Park, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) CVA DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b): Electrolyte imbalance | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 30, 1981 to Jan 31, 1981 , that (I) (we) lost saw the deceased alive on Jan 31, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Mustafa C. Oz | | DEGREE | | 22c. DATE SIGNED Jan 31, 1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MUSTAFA C. OZ, M.D. | | 22e. ADDRESS 605 BALTIMORE-ANNAPOLIS BOULEVARD SEVERNA PARK, MARYLAND 21146 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 1/31/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Security Process Inc. Catonsville Balto. | |
| 24. FUNERAL DIRECTOR NAME Mc Cully F. H. Mountain & Tick Neck Rds. 21122 | | ADDRESS Pasadena, Md. | | 25a. DATE REC'D. BY REGISTRAR FEB 3 1981 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Robert McElroy | |

2.

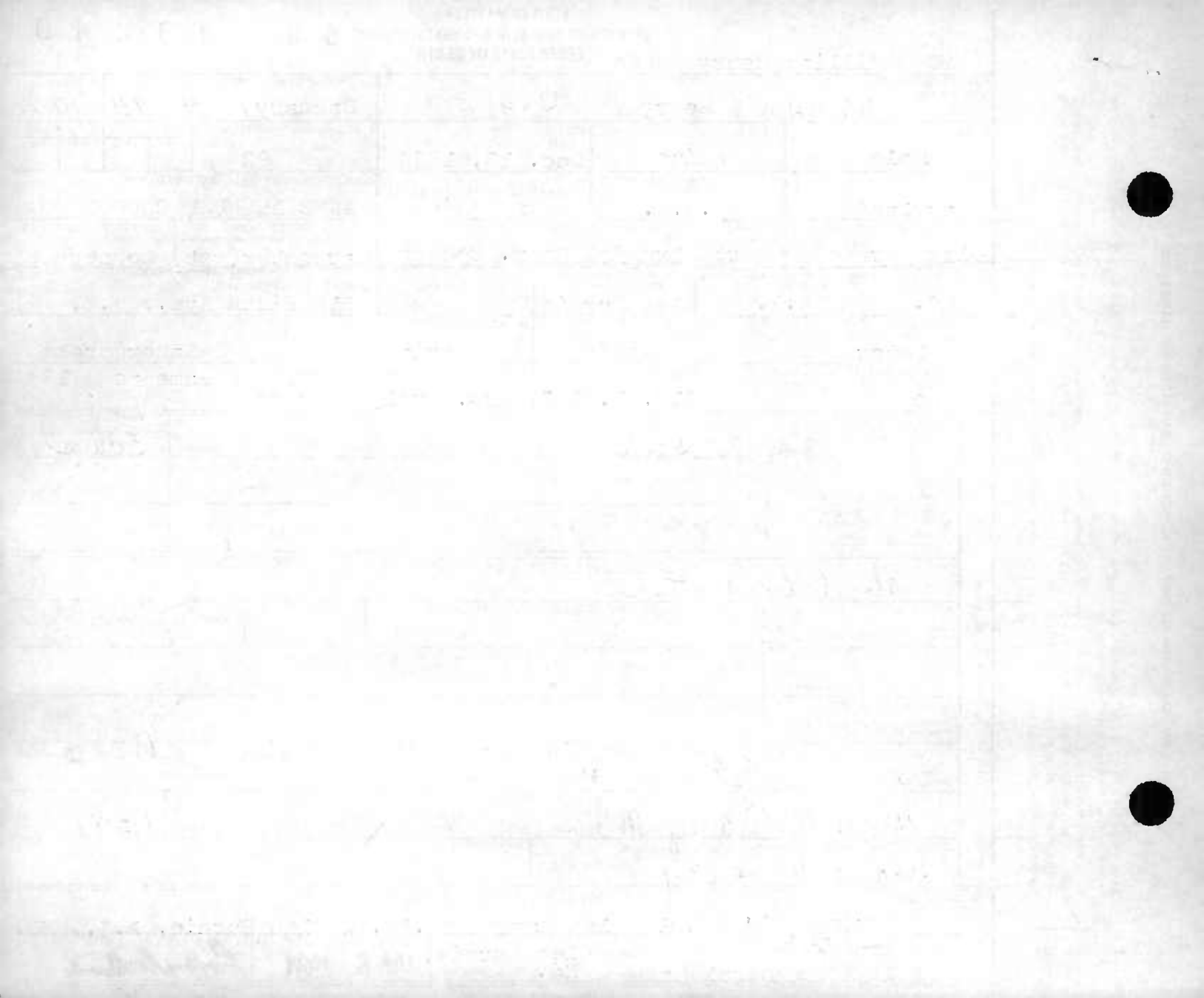
•

J.D., M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|--|--|---|--|-----------------------------------|--|
| 1- FOR STATE REGISTRAR William Henry Rohde CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST William Henry ROHDE | | | | | MONTH DAY YEAR January 4 1981 | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 2b. HOUR | |
| Male | | White | | MONTH DAY YEAR Dec. 15, 1888 | | 92 YRS. | | 10 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Glen Burnie | | North Arundel Conv. Center | | | | Carpenter (ret) | | Construction | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. A.A. Glen Burnie | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 318 Fifth Ave., S.E. | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST Peter Rohde | | | | | FIRST MIDDLE LAST Maria Sauerworski | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT (Daughter) ADDRESS | | |
| No N/A | | | | | 215.07.9293 | | Mrs. Evelyn Norkus Same as # 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Sepsis | | | | | | | | | 5 days |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| atrial fibrillation | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 22 , 19 80 , to 4 Jan , 19 81 , that (I) (we) last saw the deceased alive on 12-4 , 19 81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | 22c. DATE SIGNED | |
| Lorraine M. Dailey M.D. | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 1/5/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| LORRAINE M. DAILEY | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | 7 JAN. 81 | | Glen Haven Mem. Pk. | | Glen Burnie, A.A., MD. | | | |
| 24. FUNERAL DIRECTOR'S NAME | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| SINGLETON Funeral Home | | | | | JAN 8 1981 | | Lorraine M. Dailey | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 0 2 4 1 | |
|---|--|--|--|--|--|
| FOR 1. STATE REGISTRAR | | | | CERTIFICATE OF DEATH | |
| REG. NO. | | | | EST | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HERMAN Clinton ROLES | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 25 81 HOUR MIN 7:00 PM | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 27, 1902 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 1 HRS: HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter-Retired | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13a. STATE Maryland | | 13b. COUNTY AA | | 13c. CITY OR TOWN Pasadena | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Roles | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Boone | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 217-18-1403 | | 17. INFORMANT ADDRESS Erma Watts Roles, Same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 0799 DUE TO, OR AS A CONSEQUENCE OF (b) 20 Stroke 206 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) Severe viral respiratory | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT HOME | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/16/81 to 1/25/81 , that (I) (we) lost saw the deceased alive on 1/25/81 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death. | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE | | 22c. DATE SIGNED 1/25/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANASTACIO E. SUBONG, M.D. | | 22e. ADDRESS 7951 Oakwood Rd. Glen Burnie, Md. 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 28, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD | | 23e. DATE REC'D. BY REGISTRAR JAN 26 1981 | | 23f. REGISTRAR'S SIGNATURE [Signature] | |
| 24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, MD | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 2/80

| FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 00242 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|----------------------|--|--|--|--|--|----------------------------|--|---|--|--|--|--|--|--|--|--|--|--|--|-----------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Philip H. Ross | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR Jan 8 1981 | | | | | | | | | | 2b. HOUR 10:10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec 19 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD Jan 8 1981 | | | | | | | | | | 2d. HOUR 10:10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alaska | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co., MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Naval Officer | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY Defense | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE MD | | | | | | | | | | 13b. COUNTY AA | | | | | | | | | | 13c. CITY OR TOWN Annapolis | | | | | | | | | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | 13e. STREET ADDRESS 193 Duke of Gloucester St. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Portus H. Ross | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Hanson | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | | | | | | | 16b. SOCIAL SECURITY NO. 1923-1957 | | | | | | | | | | 17. INFORMANT Helen Ross | | | | | | | | | | ADDRESS Same as #13a | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) cardiovascular CVS DUE TO, OR AS A CONSEQUENCE OF (c) stroke DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH stroke | | | | | | | | | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE E. Linhardt | | | | | | | | | | TITLE (SPECIFY) M.D. Deputy | | | | | | | | | | MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 1-8-81 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) E. LINHARDT | | | | | | | | | | ADDRESS Annapolis, Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (RECY) Burial | | | | | | | | | | 23b. DATE Jan. 12, 1981 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY U.S. Naval Academy | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME John M. Taylor & Sons | | | | | | | | | | ADDRESS Annapolis, MD | | | | | | | | | | 25a. DATE OF U. S. REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8100243 | | EST | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NORMAN COOPER ROWENS | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 31, 1981 | | 2b. HOUR 11:20 P M | |
| 3. SEX Male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 7, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 77 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AA Co. Police | | 12b. KIND OF BUSINESS OR INDUSTRY Dept.-Ret. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md. | | 13b. COUNTY AA | | 13c. CITY OR TOWN Pasadena | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Albert F. Rowens | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally A. Kellen | | 13e. STREET ADDRESS 7790 Outing Ave. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 216-20-2563 | | 17. INFORMANT Norman C. Rowens, Son | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 ASHD DUE TO, OR AS A CONSEQUENCE OF (b) Outlet chm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) COLD - P. mmm | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/28/81, 19, to 1/31/81, 19, that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE OF PHYSICIAN Jorge B. Ramirez | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 2/1/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JORGE B. RAMIREZ, M.D. | | | | 22e. ADDRESS 7845 Oakwood Road #205 Glen Burnie, Maryland 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 4 Feb. 81 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, AA, Md. | |
| 24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie | | | | 25a. DATE REC'D. BY REGISTRAR FEB 2 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|------------------|------------------|---|--|------------------|--|---|----------------|--|--|---|--|------------------------------|------------|---|--|---|--|------|--------------|--|--|---------------|----------|--|--|------------|--|--|---------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST William | | | MIDDLE Paul | | | LAST Saliga | | | 2a. DATE KNOWN OF DEATH ESTIMATED | | | MONTH 1 | | | DAY 7 | | | YEAR 1981 | | | 2b. HOUR M | | | | | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH 8 | | DAY 15 | | YEAR 30 | | 6. AGE (IN YEARS) LAST BIRTHDAY 50 | | YRS. | | IF UNDER 1 YR. MONTHS | | DAYS | | IF UNDER 24 HRS. HOURS | | MIN. | | 2c. DATE PRONOUNCED DEAD MONTH 1 | | | DAY 9 | | | YEAR 81 | | | 2d. HOUR A | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD. | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Odenton | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 491 Saltoun Ave | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) salesman | | | | 12b. KIND OF BUSINESS OR INDUSTRY retail | | | | | | | | | | | | | | | | | |
| 13a. STATE Md | | | | | | | | | | | | 13b. COUNTY AACo | | 13c. CITY OR TOWN Odenton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 491 Saltoun Ave | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST Paul | | | | | | MIDDLE Saliga | | | | | | LAST Mary | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Mudroncik | | | | | | LAST | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1952-53 | | | | 17. INFORMANT Dorothy Devine, Odenton, Md. | | | | ADDRESS | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interosseleptic CVD</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE E. H. HAKOT | | | | TITLE (SPECIFY) M.D. Deputy | | | | MEDICAL EXAMINER | | | | DATE SIGNED 1-9-81 | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) E. H. HAKOT | | | | ADDRESS Annapolis, Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1-12-81 | | | | 23c. NAME OF CEMETERY OR CREMATORY St Marys | | | | 23d. LOCATION CITY OR TOWN Annapolis AAcO Md | | | | STATE | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Hardesty FH, 12 Ridgely Ave, Annapolis, Md, 21401 | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR JAN 13 1981 | | | | 25b. REGISTRAR'S SIGNATURE R. J. H. H. H. | | | | | | | | | | | | | | | | | | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 0 2 4 5

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) FAYE T. SAYLOR | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 18 81 | | | 2b. HOUR 5:55 AM | | | |
| 3. SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 24, 1903 | | 6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | |
| 10 CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Art Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY Pub. School | | |
| 13a. STATE MD. | | | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Severna Park | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST William R. Tackwell | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth A. Watt's | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 516-16-8433 | | 17 INFORMANT ADDRESS Kenneth D. Saylor - Sec. 13 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Lung Cancer 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 12/5 , 19 80 , to 1/18 , 19 81 , that (2) (we) last saw the deceased alive on 1/17 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Ernest W. Cole III | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/19/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ERNEST W. COLE III | | | | 22e. ADDRESS 121 CATHEDRAL ST. ANNAP. MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 1-19-81 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Mem. PK. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Westview Balto MD. | | | |
| 24. FUNERAL DIRECTOR NAME Robert S. Barrianco | | | | ADDRESS 501 Ritchie Ave. Severna Park. | | 25a. DATE REC'D. BY REGISTRAR JAN 21 1981 | | 25b. REGISTRAR'S SIGNATURE Henry McBrady | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 1 0 0 2 4 6 | | | |
|---|--|--|--|--|--|--|--|--|--|---|-----|--|----------|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| Albert | | O. | | Schwinn | | | | 1-31-81 | | | | | 7:45 PM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS. | | | |
| Male | | White | | Sept. 13, 1914 | | 66 | | MONTHS | | DAYS | | HOURS MIN. | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 9b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Baltimore, Md. | | U.S.A. | | | | Anne Arundel County, MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Annapolis | | ANNE ARUNDEL GENERAL | | | | | | | | Laborer | | Beth Steel | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. STATE | | 13c. COUNTY | | 13d. CITY OR TOWN | | 13e. INSIDE CITY LIMITS? | | 13f. STREET ADDRESS | | | |
| Md. | | Anne Arundel | | -Annapolis | | NO <input checked="" type="checkbox"/> | | 503 Tayman Drive | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| Conrad | | Florence | | No | | 213-07-1773A | | Annapolis, Md. 21403 | | Mrs. Sarah F. Carroll | | 503 Tayman Dr. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | 3 DAYS | |
| IMMEDIATE CAUSE (a) PNEUMOCOCCAL SEPSIS | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) LOBAR PNEUMONIA | | | | | | | | | | | | 5 DAYS | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) | | | | | | | | | | | | | |
| DIABETES MELLITUS, CHRONIC RENAL FAILURE, ANEMIA CHRONIC DE. | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | | | | |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN. 27, 1981, to JAN 31, 1981, that (I) (we) lost saw the deceased alive on JAN 31, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | | | |
| Thomas Marrell Holl | | M.D. | | FEB 1, 1981 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| THOS. MARRELL HOLL, M.D. | | 134 OWENSVILLE RD. WEST RIVER, MD. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | |
| Burial | | 2/3/81 | | Parkwood Cemetery | | Baltimore, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| John A. Moran, Inc. | | | | | | | | | | | | | |
| 3000 E. Baltimore St. | | | | | | | | | | | | | |

.99214255

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 1 0 0 2 4 7

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ETHEL M. SEICKE | | 2a. DATE OF DEATH MONTH 1 DAY 4 YEAR 1981 | | 2b. HOUR 10:15 AM | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH 8 DAY 29 YEAR 06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD. | |
| 10. CITY OR TOWN OF DEATH Crownsville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairfield Nursing Center | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | 13c. CITY OR TOWN Severn | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST Paul MIDDLE Hiner LAST Hiner | | 15. MOTHER'S MAIDEN NAME FIRST Catherine MIDDLE UNKNOWN LAST UNKNOWN | | 16. ADDRESS W. Edmondale | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 216-18-9243 | | 17. INFORMANT Shirley L. Wimer 5531 Channing Rd. 21229 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left ventricular failure DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Progressive atherosclerosis of old age APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from 10 August 1972 to 4 January 1981 , that (I) last saw the deceased alive on 5 Nov 80 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) do (did) not view the body after death. | | | | | |
| 22b. SIGNATURE Charles W. Kinzer | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 3 Jan 81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles W. Kinzer | | 22e. ADDRESS Annapolis, MD, 21401 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/8/81 | | 23c. NAME OF CEMETERY OR CREMATORY Good Shepard Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Ellicott City Howard Co. Md. | | 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Balto., Md. 21229 | | | |
| 25a. DATE REC'D. BY REGISTRAR JAN 7 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

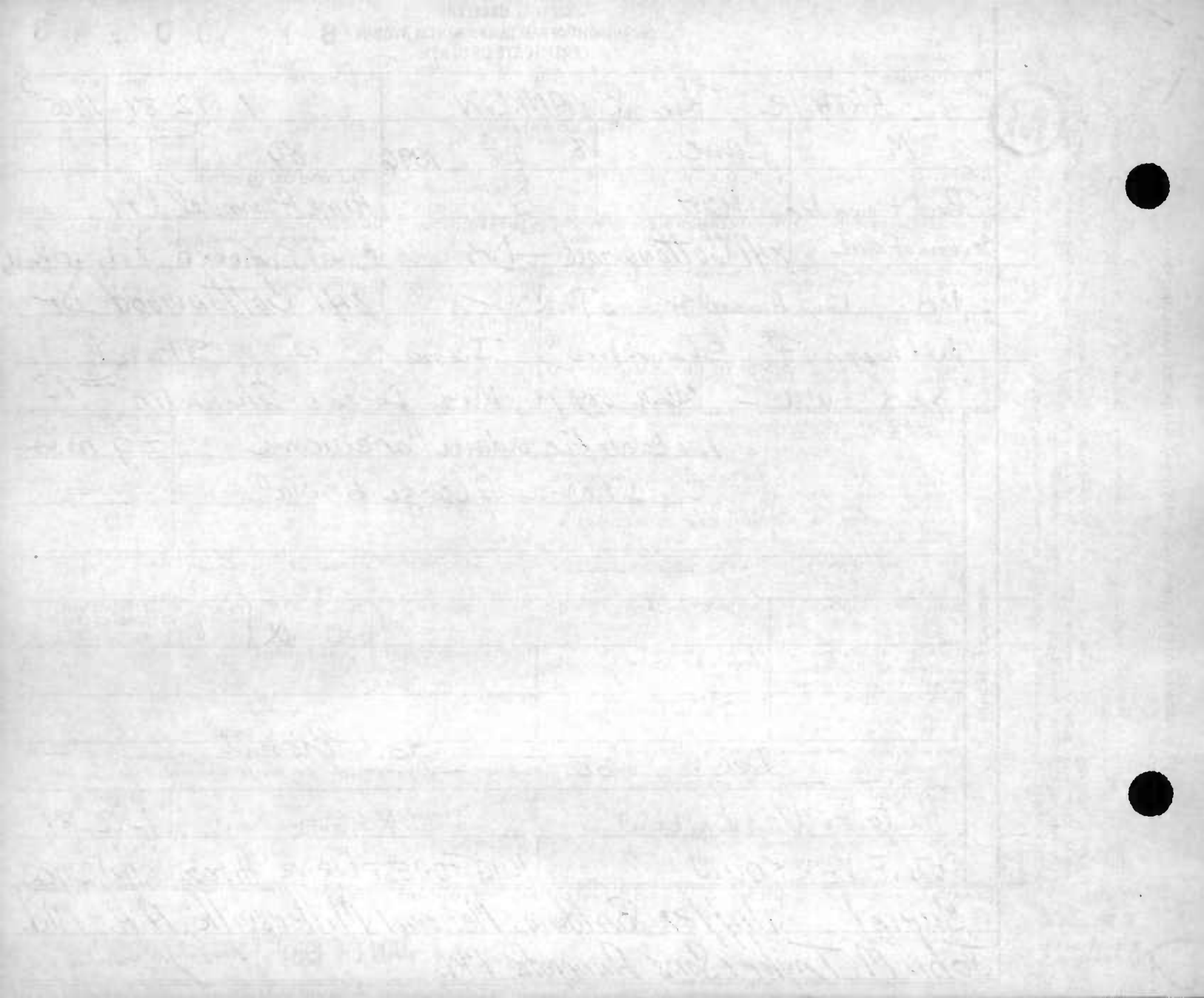
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 1 0 0 2 4 8 | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) ARTHUR PERCIVAL SHANKLIN | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 12 81 | | 2b. HOUR 11:05 A. | | M | |
| 3. SEX M | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 8 28 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Cty MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Severna Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 841 Cottonwood Dr. | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY City of Balto. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md. | | | | | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Severna Park | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Arthur P Shanklin | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane G. Stank | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I | | 17. INFORMANT Mrs. Dorcas Shanklin | | | | #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic adenocarcinoma 1590 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Large bowel DUE TO, OR AS A CONSEQUENCE OF (c) — | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ± 9 mos | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from Dec. 1980 , to Present , 19 80 , that (I) was lost saw the deceased alive on Dec. 1980 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Peter F. Verkouwen | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-12-81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter F. VERKOUWEN | | | | | | 22e. ADDRESS 1419 FOREST DRIVE, ANNAPOLIS, MD 21403 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 1/14/81 | | 23c. NAME OF CEMETERY OR CREMATORY Baldwin's Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Millersville, A.A. Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS John M. Taylor & Sons Annapolis, Md. | | | | | | 25a. DATE REG'D. BY REGISTRAR JAN 1 1981 | | 25b. REGISTRAR'S SIGNATURE John M. Taylor | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 1 0 0 2 4 9

| | | | | |
|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>George Maurice Shipley</i> | | 2a. DATE OF DEATH MONTH <i>1</i> DAY <i>13</i> YEAR <i>1981</i> | | 2b. HOUR <i>2:00 PM</i> |
| 3. SEX <i>Male</i> | 4. RACE <i>White</i> | 5. DATE OF BIRTH MONTH <i>5</i> DAY <i>30</i> YEAR <i>1900</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>80</i> YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD |
| 10. CITY OR TOWN OF DEATH <i>Pasadena</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>7906 Shipley Drive</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Maintenance</i> | 12b. KIND OF BUSINESS OR INDUSTRY <i>Bakery</i> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i> 13b. COUNTY <i>Anne Arundel</i> 13c. CITY OR TOWN <i>Pasadena</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS <i>7906 Shipley Drive 21122</i> | |
| 14. FATHER'S NAME FIRST <i>John</i> MIDDLE <i>Franklin</i> LAST <i>Shipley</i> | | 15. MOTHER'S MAIDEN NAME FIRST <i>Mary</i> MIDDLE <i>Virginia</i> LAST <i>Clark</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>212-10-1600</i> | | 17. INFORMANT ADDRESS <i>Elsie K. Shipley same as 13</i> |

MEDICAL CERTIFICATION

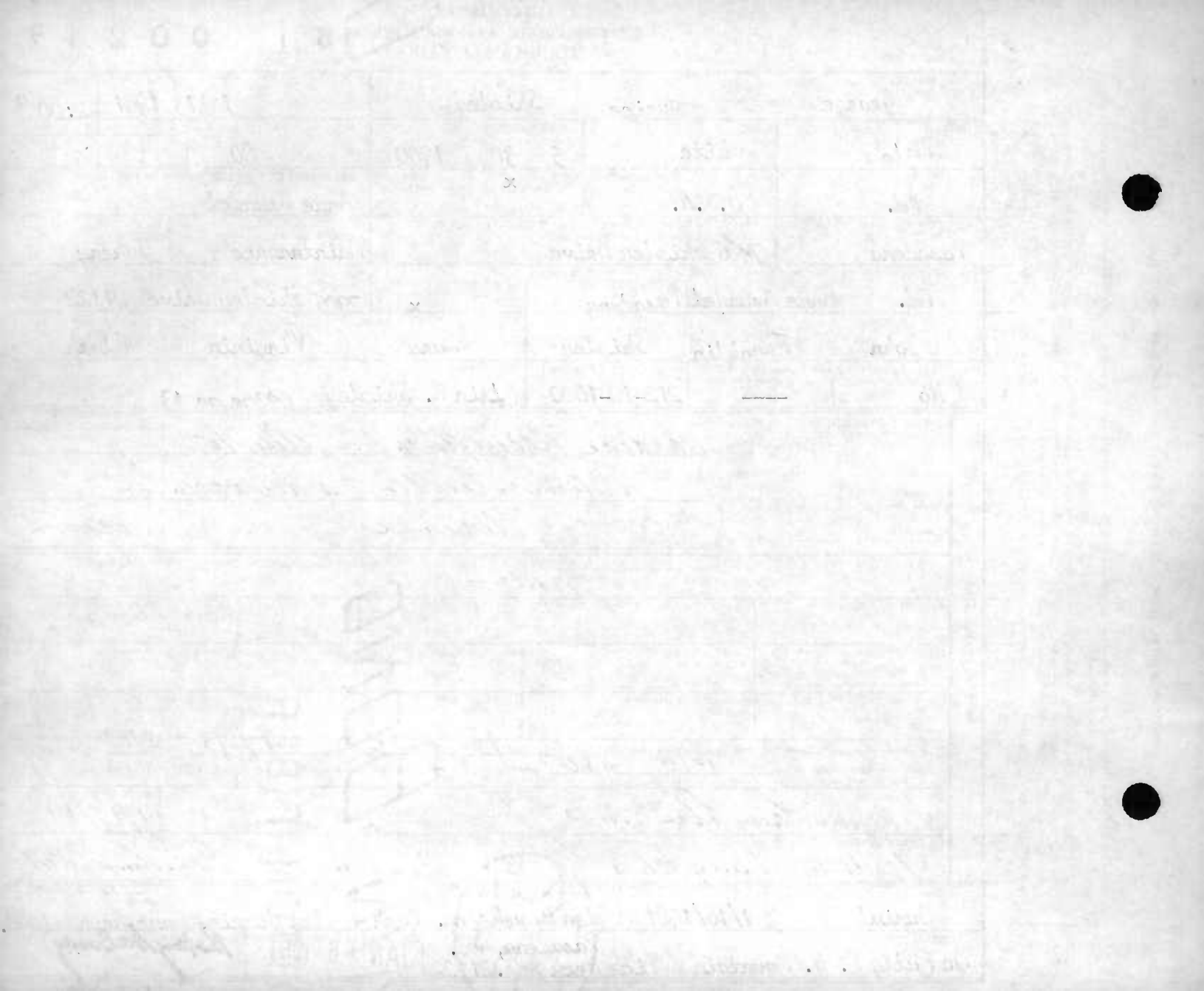
| | | |
|---|--|--|
| 18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac decompensation due to</i> <i>429.2</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>arteriosclerotic Cardiovascular</i> (c) <i>disease</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i> |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *none*

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6/7</i> , 19 <i>72</i> , to <i>1/13</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>12/15</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE <i>R. M. McCaughrin, M.D.</i> | | DEGREE | 22c. DATE SIGNED <i>1/13/81</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. M. McCaughrin</i> | | 22e. ADDRESS <i>3708 Mountain Rd. Pasadena, Md.</i> | |

| | | | |
|--|-------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | 23b. DATE <i>1/16/1981</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem. Park</i> | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Glen Burnie Anne Arundel Md.</i> |
| 24. FUNERAL DIRECTOR NAME ADDRESS <i>McCully F. H. Mountain & Tick Neck Rds. 21122</i> | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 16 1981</i> | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 0 0 2 5 0 | | EST | |
|--|--|--|--|---|--|--|--|
| FOR 1. STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) CHARLES CONRAD SMITH | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 7, 1981 | | 2b. HOUR 8:05A_M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 29, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mailer | | 12b. KIND OF BUSINESS OR INDUSTRY Balto News American | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 13a. STATE Md. | | 13b. COUNTY A.A. Co. | | 13c. CITY OR TOWN Pasadena | | 13d. STREET ADDRESS 214 Pinewood Dr. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Phillip J. Smith | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Etta unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI+II 215 12 7563 | | 17. INFORMANT ADDRESS William E. Wenker same as 13 e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 58550 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Atherosclerotic Heart Disease; Congestive Heart Failure; Anemia; U.T.I.'s; Senile Dementia</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/19/80</u> 19 <u>80</u> , to <u>1/7/81</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>1/6/81</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>H. K. Bhasin</u> | | | | DEGREE MD. | | 22c. DATE SIGNED <u>1/7/81</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARI K. BHASIN, M.D. | | | | 22e. ADDRESS 1404 CRAIN HWY.S., GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/10/81 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland MD. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS George J. Gonce 4001 Ritchie Hwy. Balto 21225 | | | | 25a. DATE REC'D BY REGISTRAR JAN 12 1981 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR | | STATE OF MARYLAND | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8100251 | |
|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 3. SEX | | 4. RACE | |
| Clarice E. Smith | | 1-14-81 | | FEMALE | | WHITE | |
| 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | |
| 2 23 1907 | | 73 | | WASH. D.C. | | USA. | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | |
| | | Anne Arundel | | Annapoles | | Anne Arundel General Hosp | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. USUAL RESIDENCE (CITY OR TOWN AND STATE) | | 13b. CITY OR TOWN | |
| Housewife | | Home | | MD | | A.A.G. ARNOUD | |
| 13c. STREET ADDRESS | | 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | |
| 103 Church Rd. | | LEE F. BEALL | | MARY E. HART | | NO | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 220-16-4442 | | ADOLE BERGER | | 1579 Respiratory Arrest | | | |
| | | 109 SPICHER DR. ANNAPOLIS MD | | Concussion of the Pancreas | | 1 yr. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 11, 19 81, to JAN 14, 19 81, that (I) (we) lost the deceased alive on JAN 13, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.) | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| Barry R. Nathanson | | ATTENDING PHYSICIAN | | 1/15/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| BARRY NATHANSON | | 2568 RIVA RD. ANNAPOLIS MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (City) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) COUNTY STATE | |
| BURIAL | | 1-17-81 | | GLEN HAVEN CEM. | | GLEN BERNIE AA. MD. | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| John M. Taylor | | Sons Annapolis MD | | JAN 19 1981 | | History McBray | |

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25.4.2

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

8100252

1 FOR
STATE
REGISTRAR

SOPHIE KATHERINE SMITH

REG. NO.

| | | | | | | |
|---|--|--|---|--|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sophie Katherine Smith | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN. 2-81 | | 2b. HOUR 8:50 AM | |
| 3 SEX FEMALE | | 4 RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR JAN. 26, 1882 | | |
| 6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. AGE (IN YEARS LAST BIRTHDAY) 98 YRS | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | 10. CITY OR TOWN OF DEATH BROOKLYN PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HAMMONDS LANE NURSING CENTER | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 13a. STREET ADDRESS 759 HAWTHORNE ROAD | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SIMONE SCHABDACH | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE SCHUBERT | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | |
| 16b. SOCIAL SECURITY NO. 220.44.1176 | | 17. INFORMANT (Daughter) Mrs. Helen Cooper | | ADDRESS Same As # 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (c) PNEUMONIA, ORGANIC BRAIN SYNDROME. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) PNEUMONIA, ORGANIC BRAIN SYNDROME. | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/20/1979 to 1/1/1981 , that (I) (we) lost saw the deceased alive on 1/2/1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE K. Dharma Sena | | DEGREE M.D. | | 22c. DATE SIGNED 1/2/1981 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. DHARMA SENA. | | 22e. ADDRESS #8, 16th AVE. BALTIMORE MD 21205 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5 JAN. 81 | | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEM. | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY, MD. | | 24. FUNERAL DIRECTOR NAME GLEN BURNIE | | 25a. DATE REC'D. BY REGISTRAR JAN 5 1981 | | |
| 25b. REGISTRAR'S SIGNATURE Barney McBrady | | 25c. REGISTRAR'S NAME SINGLETON FUNERAL HOME MARYLAND | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81

00253

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|--|--|--|---|
| 1 DECEASED NAME (TYPE OR PRINT) LOTTIE B. SMITHSON | | 2a DATE OF DEATH MONTH DAY YEAR 1-15-81 | | 2b HOUR 5:45 M | |
| 3 SEX Female | | 4 RACE WHITE | | 5 DATE OF BIRTH MONTH DAY YEAR 6-25-88 | |
| 6 AGE (IN YEARS LAST BIRTHDAY) 92 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 14 HRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD | | 10 CITY OR TOWN OF DEATH Brooklyn | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hammonds Lane Nursing Home | |
| 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| 13a STATE Md. | | 13b COUNTY A.A. Co. | | 13c CITY OR TOWN Baltimore | |
| 14 FATHER'S NAME FIRST MIDDLE LAST William Slaughter | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophia Schriver | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218 09 0356 | | 17 INFORMANT ADDRESS Thelma Rogers 313 15th Ave. Balto Md. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 1a) Carcinoma Left Breast 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a) Arteriosclerotic Coronary Vascular Disease; Degenerative Osteoarthritis; Hiatal Hernia | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Michael Palmer MD | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/15/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/17/81 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | 24 FUNERAL DIRECTOR NAME George J. Gonce | | 25a. DATE REC'D. BY REGISTRAR JAN 19 1981 | |
| 25b. REGISTRAR'S SIGNATURE Richard M. [Signature] | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

U.S. DEPT. OF JUSTICE

INVESTIGATION

WITNESS

U.S.A.

CHARGE

CHARGE

CHARGE

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8100254

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Ida F. Smoot | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/16/81 | | | 2b. HOUR 1:40 PM | | | | |
| 3. SEX FEMALE | | 4. RACE Caucasian White | | 5. DATE OF BIRTH MONTH DAY YEAR 2 7 03 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, Anne Arundel, MD | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hammonds Lane Convalescent | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher - Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | | 13b. COUNTY AA | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 405 Delmar Avenue, S.E. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Bernard Friese | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie Tusing | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 214-10-0030 | | 17. INFORMANT ADDRESS Jerome K. Smoot, Same as 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Coronary Artery Disease 4/40 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Obstructive Pulmonary Disease, Left peroneal nerve palsy | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Michael Schwartz MD | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 1/16/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Schwartz, M.D. | | | | | 22e. ADDRESS Hammonds Lane Med. Center | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Jan. 20, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, MD | | | | | 25a. DATE RECD. BY REGISTRAR JAN 20 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

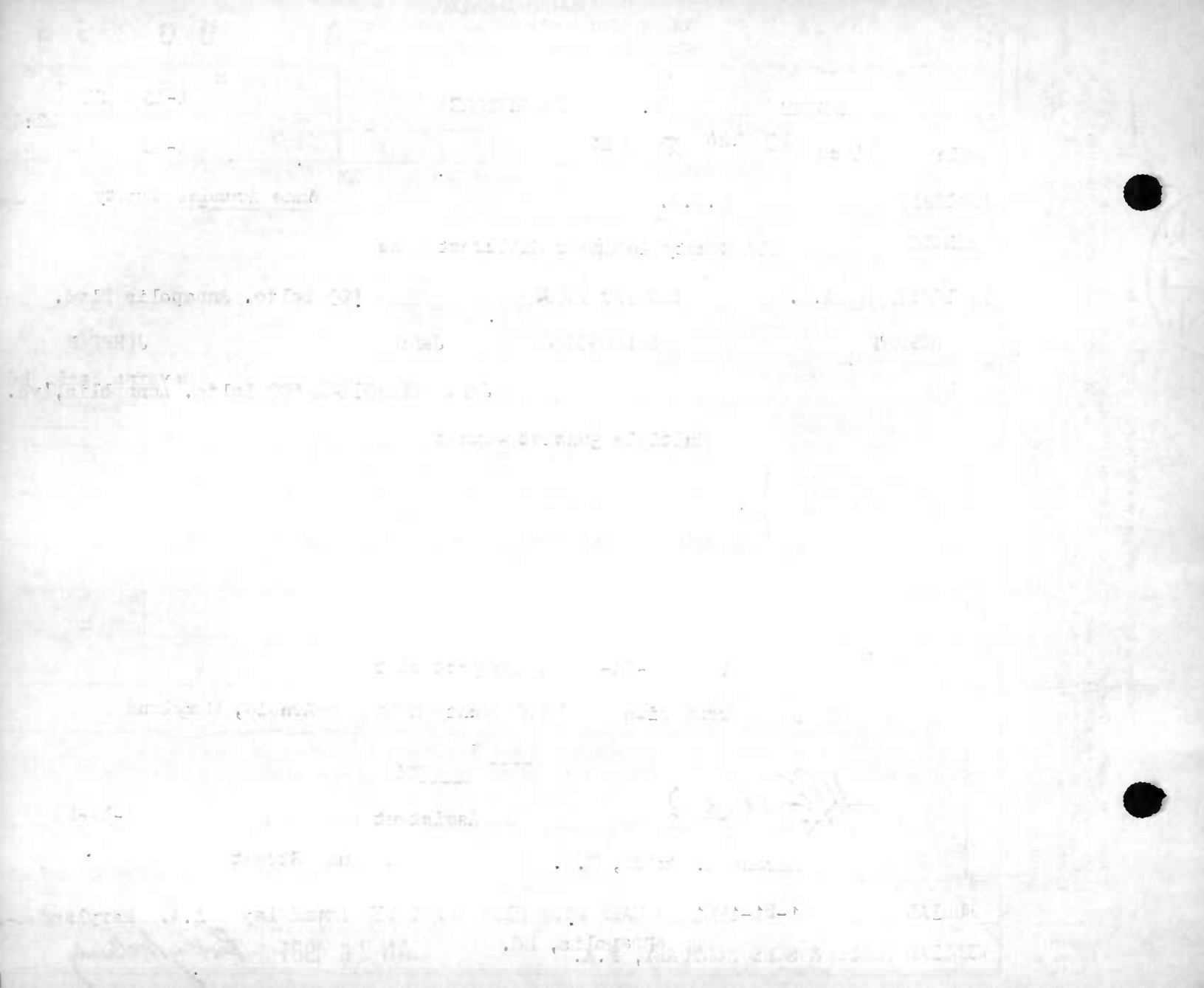
NO. 554

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M2/80


| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 00255 | |
|---|-------------------------|--|---|---|------------------|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ROBERT D. SOMERVILLE | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1-15 1981 | |
| 3 SEX male | 4. RACE black | 5. DATE OF BIRTH MONTH DAY YEAR 3 24 53 | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 27 | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-15 1981 | | 2b. HOUR 12:45 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County | | | | | |
| 10. CITY OR TOWN OF DEATH ARNOLD | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Old County Road near Hillcrest Lane | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN SEVERNA PARK | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 903 Balto. Annapolis Blvd. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ROBERT SOMERVILLE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JANE JOHNSON | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS JANE SOMERVILLE 903 Balto. Severna Park, Md. Annapolis Blvd. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple gunshot wounds 9654 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 1-14- 19 81 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road side | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Old County Road Arnold, Maryland | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE H. Suaw | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED 1-15-81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. | | ADDRESS 111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1-21-1981 | | 23c. NAME OF CEMETERY OR CREMATORY CARPENTER HILL CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE Round Bay A.A. Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS WILLIAM REESE & SONS MORTUARY, P.A. Annapolis, Md. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 26 1981 | | 25b. REGISTRAR'S SIGNATURE Robert McCreedy | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 00256 | |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Lorraine Staeps | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> 1 2 1981 | |
| 3. SEX female 4. RACE white 5. DATE OF BIRTH March 1, 1921 6. AGE (IN YEARS) 59 YRS. 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | | | | | | | 2b. HOUR PM | |
| 10. CITY OR TOWN OF DEATH Annapolis 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 306 Chester Avenue | | | | | | | | | | 2c. DATE PRONOUNCED DEAD 1 2 19 81 2d. HOUR 6:00 | |
| 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY A.A. 13c. CITY OR TOWN Annapolis 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 306 Chester Ave. | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD. | |
| 14. FATHER'S NAME Thomas Lambert 15. MOTHER'S MAIDEN NAME Irma Bertha Meyer | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unkn. (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 551-22-5552 17. INFORMANT (Attorney) ADDRESS Wayne T. Kosmerl P.O. Box 3323 21403 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: Gun shot wound of head Gun: Handgun IMMEDIATE CAUSE (a) 9550 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY (HO) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Noon P.M. 1/2 1981 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self inflicted gun shot wound | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home 21f. LOCATION 306 Chester Ave, Annapolis, AA county, MD | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> (Head Only) <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Hormez R. Guard M.D. Assistant MEDICAL EXAMINER DATE SIGNED 1/3/81 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal 23b. DATE 1/23/81 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board ADDRESS Balto., Md. 25a. DATE REC'D. BY REGISTRAR JAN 28 1981 25b. REGISTRAR'S SIGNATURE Hickory McCreedy | | | | | | | | | | | |

2015-01-06 10:00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 00257

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Christopher A Stanley | | | 2a. DATE OF DEATH MONTH DAY YEAR January 28 1981 | | | 2b. HOUR PM 3 PM | | | |
| 3 SEX M | | 4 RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR March 30 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Balt. City Police | | 12b. KIND OF BUSINESS OR INDUSTRY Ret | |
| 13a. STATE MD | | | | 13b. COUNTY AA | | 13c. CITY OR TOWN Annapolis | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel D Stanley | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Engel Breit | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-32-7858 | | 17. INFORMANT ADDRESS Margaret Stanley same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration 3030 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Severe Dehydration (c) Former alcoholism | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 day Yr. Yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> (OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 76 to 1/28 19 81 , that (I) (we) last saw the deceased alive on 1/28 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Joseph N. Frisner | | | DEGREE M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/28/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph N. Frisner | | | 22e. ADDRESS 1616 Forest Dr. Annapolis, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (IF BY) | | | 23b. DATE Jan 31, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD | | |
| 24. FUNERAL DIRECTOR NAME Nabach Funeral Home | | | ADDRESS Owings Md | | | 25a. DATE RECEIVED BY REGISTRAR FEB 2 1981 | | | |

BP



UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

U. S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 0 2 5 8

REG. NO.

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Daisy B. Stansbury</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>1 / 14 / 81</i> | | 2b. HOUR <i>M</i> |
| 3. SEX <i>Female</i> | 4. RACE <i>Black</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>06 / 04 / 11</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>69</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) <i>MARYLAND</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel Co.</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Annapolis</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel General Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE <i>MARYLAND</i> | 13b. COUNTY <i>A.A.</i> | 13c. CITY OR TOWN <i>ANNAPOLIS</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS <i>2170 Mulberry Hill Road</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>GEORGE COOK</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>CARRIE FLEETWOOD</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>213-36-3856</i> | 17. INFORMANT ADDRESS <i>CHARLES STANSBURY 2170 Mulberry Hill Rd. Annapolis, Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Stroke</i> <i>4292</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Hypertension</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Cardiovascular disease</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i> <i>Years</i> <i>Years</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/12</i> 19 <i>81</i> , to <i>5/14</i> 19 <i>81</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death. | | | | | |
| 22b. SIGNATURE <i>James Chaconas M.D.</i> | | | | 22c. DATE SIGNED <i>1/14/81</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James Chaconas</i> | | 22e. ADDRESS <i>1521 Ritchie Hwy Annapolis, Md</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | 23b. DATE <i>1-19-1981</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>ASBURY BROADNECK CEME</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>St. Margarets A.A. Maryland</i> |
| 24. FUNERAL DIRECTOR NAME <i>WILLIAM REESE & SONS MORTUARY, P.A.</i> | | | 25a. DATE RECD. BY REGISTRAR <i>JAN 16 1981</i> | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 months after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 0 2 5 9

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|---|---|--|--|------------------------------------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| JAMES FRED STEHLE | | | 1-10-81 | | | 230A M | | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | |
| MALE | WHITE | 2-6-14 | 66 | | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| AAG MD. | U.S.A. | | ANNE ARUNDEL MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| ANNAPOLIS | ANNE ARUNDEL GEN. HOSPITAL | | Bldg Contractor Const. | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | |
| MD. | | | A.A. | | | ANNAPOLIS. | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13d. INSIDE CITY LIMITS? | | |
| FREDERICK W STEHLE | | | VIOLEA WILLIAMS | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| NO | | | 214050889 | | | LOUISE M. STEHLE #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CUA</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ASLUD</u> (c) <u>MI</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1977</u> , 19____, to <u>1/10/81</u> , 19____, that (I) (we) last saw the deceased alive on <u>1/9/81</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>Stanley P. Watkins</u> | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>1/12/81</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY P. WATKINS | | | | | | 22e. ADDRESS ANNAPOLIS MD. | | |
| 23a. BURIAL, CREMATION, REMOVAL (CITY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| BURIAL | | | 1-13-81 | | CEDAR BLUFF CEM. | | ANNAPOLIS MD. | |
| 24. FUNERAL DIRECTOR NAME | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| John H. Larkins | | | JAN 14 1981 | | | [Signature] | | |



[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]

[Faint handwritten text at the bottom of the page, possibly a signature or date.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 81 00260 | |
|--|--|---|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN Henry STEENEY | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 29 1981 | | | | 2b. HOUR 1:35 PM | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 3 31 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL Co MD. | | | | | |
| 8. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gen. Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Md | | 13b. COUNTY AA, Crownsville | | 13c. CITY OR TOWN Crownsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1612 Crownsville Rd | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN Steeney | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Catherine Johnson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 220-07-1644 | | 17. INFORMANT NAME MARIE M. CARROLL | | | | ADDRESS 1612 Smead St | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure, uremia 4292 DUE TO, OR AS A CONSEQUENCE OF (b) A & D - Nerve Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-14-81 19 to 1-29-81 19, that (I) (we) lost saw the deceased alive on 1-29-81 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | DEGREE MD | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-30-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. J. ALLEN | | | | 22e. ADDRESS 111 Calverly St | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Feb. 2-81 | | 23c. NAME OF CEMETERY OR CREMATORY WILSONS | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville AA Md | | | |
| 24. FUNERAL DIRECTOR C. E. HICKS | | | | 24b. ADDRESS ANNAPOLIS-MD | | | | 25a. DATE REC'D. BY REGISTRAR FEB 9 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

BP

June 1890

General Anne Hanson General Hospital



FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

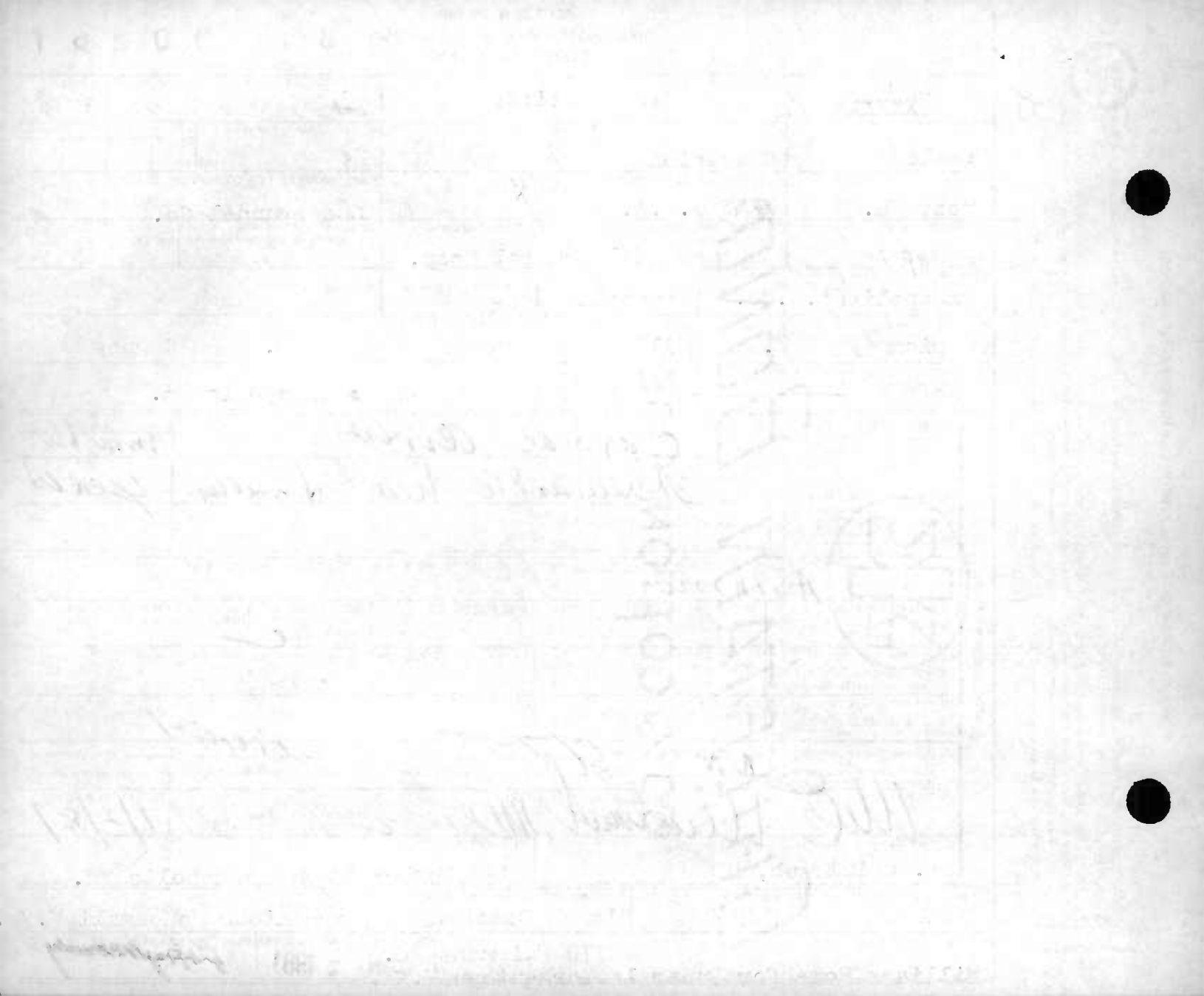
81 00261

REG. NO.

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) XXXXXX Rose M Stitt | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 - 1 81 | | 2b. HOUR 3:48 M |
| 3. SEX Female F | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR 10 21 35 | | 6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Va. | 7b. CITIZEN OF WHAT COUNTRY? XXXX U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD. | | |
| 10. CITY OR TOWN OF DEATH Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Annapolis A.A.CO. | | | 13b. COUNTY A.A.CO. | 13c. CITY OR TOWN Annapolis | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Marion W. Miller | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah H. Carnes | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 233567747 | | 17. INFORMANT ADDRESS Edward Stitt, Annapolis Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 3989 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Rheumatic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Asthma</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/2/81</u> to <u>Present</u> , that (I) (we) lost saw the deceased above (I) (we) did (did not) view the body after death. <u>1981</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | |
| 22b. SIGNATURE <u>Dr. Weintraub, MD</u> | | 22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22d. DATE SIGNED 1/2/81 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Weintraub, MD | | 22f. ADDRESS 140 Forbes Street Annapolis Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1/5/81 | 23c. NAME OF CEMETERY OR CREMATORY Pisgah Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Morgantown Monongalia W. Va. | |
| 24. FUNERAL DIRECTOR NAME Williams Home for Funerals Morgantown W. Va. | | ADDRESS 770 Fairmont Rd. | | 25a. DATE REC'D. BY REGISTRAR JAN 5 1981 | 25b. REGISTRAR'S SIGNATURE <u>Robert H. Brady</u> |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 7 copies of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

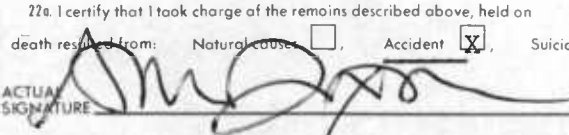

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 81 | 00262 | EST |
|--|--|--|--|--|--|--|--|--|--|----|-------|-----|
| 1- FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALFRED H. STRAN | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 12, 1981 | | 2b. HOUR 6:55 P _M | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 22, 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 9. CITIZEN OF WHAT COUNTRY? U.S.A. | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | | | |
| 11. CITY OR TOWN OF DEATH GLEN BURNIE | | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Store Manager | | 13b. KIND OF BUSINESS OR INDUSTRY Grocery | | | | |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Baltimore 21204 | | | | | | 14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 15. STREET ADDRESS 1652 Myamby Road | | | | |
| 16. FATHER'S NAME FIRST MIDDLE LAST Franklin W. Stran | | | | 17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Bliss | | | | | | | | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | 18b. SOCIAL SECURITY NO. 213-01-7769 | | 19. INFORMANT ADDRESS William A. Stran 1652 Myamby Road 21204 | | | | | | |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIAF</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PSUD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Brunchitis</u> | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>organic brain disease</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/2</u> , 19 <u>81</u> , to <u>11/2</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>11/2</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Robert B. Kroopnick</u> | | | | DEGREE <u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/2/81 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT B. KROOPNICK, M.D. | | | | 22e. ADDRESS 205 Baltimore-Annapolis Blvd. Glen Burnie, Md. 21061 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 15, '81 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co., Maryland | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS William E. Johnson 8521 Loch Raven Blvd. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 14 1981 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | |

BP

[Faint, mostly illegible text covering the main body of the page, possibly a memorandum or report.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DETAILS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 00263 | |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) JOHN LLOYD TARMAN | | | | | | | | | | 2b. DATE KNOWN OF DEATH 1 17 19 81 | |
| 3. SEX male 4. RACE white 5. DATE OF BIRTH Aug. 6, 1941 6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS. | | | | | | | | | | 2c. DATE PRONOUNCED DEAD 1 17 19 81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C. 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County | |
| 10. CITY OR TOWN OF DEATH Annapolis 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp. (DOA) 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer 12b. KIND OF BUSINESS OR INDUSTRY Construction | | | | | | | | | | | |
| 13a. STATE Maryland 13b. COUNTY Prince Geo. 13c. CITY OR TOWN Bowie 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 12666 Heming Lane | | | | | | | | | | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) John Smallwood 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Gladys Mae Martin | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 578 56 7412 17. INFORMANT ADDRESS Marianne Ballew Same as #13 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture dislocation of atlanto-occipital joint 8120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 9:07 P.M. 1-17- 19 80 21b. TIME OF INJURY HOUR 9:07 MONTH 1 DAY 17 YEAR 19 80 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in van/auto collision. | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK road 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Rt. 4 21f. LOCATION CITY OR TOWN Lothian COUNTY Anne Arundel STATE Md. | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE  TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 1-18-81 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 1/22/81 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery 23d. LOCATION CITY OR TOWN Brentwood COUNTY P.G. STATE Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland 25a. DATE BY REGISTRAR JAN 20 1981 25b. REGISTRAR'S SIGNATURE  | | | | | | | | | | | |

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Mr. J. H. ...

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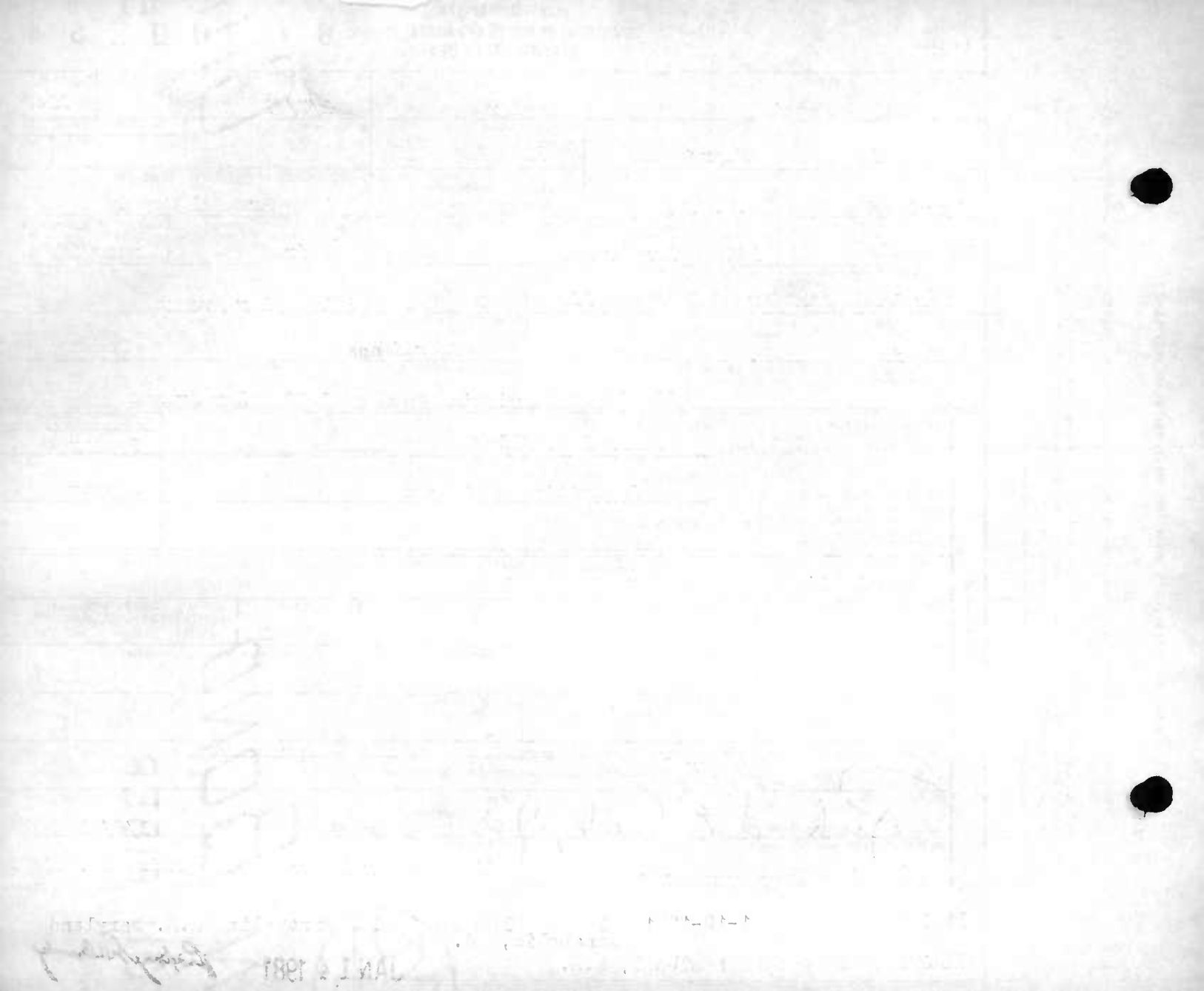
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|---|--|--|--|---|--|---|
| 1. FOR STATE REGISTRAR | | | REG. NO. 81 00264 | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR |
| Hattie Taylor | | | | | | 1/7/81 | | | 11:30 AM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS | |
| Female | | Negro | | 11 14 95 | | 85 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Anne Arundel County MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Annapolis | | 1420 Tyler Avenue | | | | Retired | | Housewife | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? |
| Maryland | | | | | Anne Arundel | | Annapolis | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | |
| Louis B. Weems | | | | | Georgianna Weems | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | |
| No | | | 219-30-6400 | | Aristine Jacobs 1420 Tyler Avenue | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Debility | | | | | | | | | 3 years |
| 2639 } DUE TO, OR AS A CONSEQUENCE OF (b) Malnutrition & Old age | | | | | | | | | 5 years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| Total blindness secondary to glaucoma. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| | | | 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 6, 1968, to present, 1981, that (I) (we) last saw the deceased alive on October 15, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| Richard E. Cook, M.D. | | | | | | | | 1/9/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | |
| Richard Eugene Cook, M.D. | | | 113 Cathedral Street Annapolis, Md. 21401 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| BURIAL | | | 1-10-1981 | | BREWER HILL CEMETERY | | Annapolis A.A. Maryland | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| WILLIAM REESE & SONS MORTUARY, P.A. | | | | | | JAN 14 1981 | | R. E. Reese | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 00265 | |
|--|------------------|---|--|---|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR 4/2/81 jlb | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MICHAEL V. TAYLOR | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1 25 1981 | | 2b. HOUR M | | | |
| 3. SEX male | 4. RACE negro | 5. DATE OF BIRTH MONTH DAY YEAR July 10, 1946 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 34 | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 1 26 1981 | | 2d. HOUR 1:30 P M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) off of Watkins Farm | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Washington, D.C. | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3357 Alden Place, N.E. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Taylor | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Arletha H. Sanders | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | | | 16b. SOCIAL SECURITY NO. 527-64-1470 | | 17. INFORMANT 3357 Alden Pl., N.E. Mrs. Arletha H. Taylor-mother | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple gunshot & puncture wounds (unspecified weapon) DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 1- 25- 1981 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot and stabbed. | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) found off of | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Watkins Farm Anne Arundel, Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 1-26-81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Feb. 10, 1981 | | | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln | | | |
| | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Stewart Funeral Home | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 10 1981 | | 25b. REGISTRAR'S SIGNATURE | | | |
| ADDRESS 4001 Benning Road, NE | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|----------------------|
| 1. FOR STATE REGISTRAR | | REG. NO. 8100266 | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST <i>John</i> | | MIDDLE <i>NM</i> | | LAST <i>Thomas, Jr.</i> | | 2a. DATE OF DEATH MONTH DAY YEAR <i>January 22, 1981</i> | | 2b. HOUR <i>M</i> |
| 3 SEX <i>Male</i> | | 4 RACE <i>Caucasian</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>May 7, 1900</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>80</i> | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Hungary</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County</i> MD. | | | | |
| 10. CITY OR TOWN OF DEATH <i>Linthicum</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>113 S. Orchard Avenue</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Stillman</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Oil Refinery</i> | | |
| 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>Anne Arundel</i> | | 13c. CITY OR TOWN <i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS <i>2 W. 1st. Avenue</i> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>John NM Thomas, Sr.</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Theresa Unknown</i> | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | | | |
| 16b. SOCIAL SECURITY NO. <i>213-05-3924</i> | | 17. INFORMANT <i>Mrs. Dorothy M. Collison</i> | | | | ADDRESS <i>Linthicum, Md. 21090</i> <i>113 S. Orchard Ave.</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of the colon with</i> <i>1539</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>colic metastasis.</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | DEGREE <i>M.D.</i> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>1/23/81</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DR. R. MADIN</i> | | 22e. ADDRESS <i>STAGERS MED CTR 21229</i> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>1/26/81</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Anne Arundel Md.</i> | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Mc Cully Funeral Home of Brooklyn</i> <i>237 E. Patapsco Avenue Baltimore, Md. 21225</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 27 1981</i> | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | |

1991-5 SPAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | 8 1 0 0 2 6 7 | |
|---|--|---|--|---|---|--|
| FOR STATE REGISTRAR | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Amy M. Twigg | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-26-81 | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11-19-1936 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 8. AGE (IN YEARS LAST BIRTHDAY) 84 YRS | | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 9b. CITIZEN OF WHAT COUNTRY? USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | | |
| 10. CITY OR TOWN OF DEATH CROWNSVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FAIRFAX NURSING CENTER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker | | |
| 13a. STATE Md. | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Millersville | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Kimberly Winfield | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Elizabeth Bennett | | 16. SOCIAL SECURITY NO. 213-24-6397 | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 17b. SOCIAL SECURITY NO. 213-24-6397 | | 17. INFORMANT ADDRESS Anita M. Waters Millersville Md. | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of head & pancreas 1570 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8-12 months | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Heart trouble Slaucoma | | | | | | |
| 19a. DATE OF OPERATION May 80 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Obstructive Jaundice | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) No accident injury | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/26/81 to 1/26/81, that I (we) (am) (are) saw the deceased live and above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Charles H. Wirth MD | | DEGREE | | 22c. DATE SIGNED 1/26/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles H. Wirth | | 22e. ADDRESS Lothian Md 20820 | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/28/81 | | 23c. NAME OF CEMETERY OR CREMATORY Mt Savage Cem. | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Mt Savage Md Allegany Co | | 23e. DATE BURIED BY REGISTRAR FEB 2 1981 | | 23f. REGISTRAR'S SIGNATURE | | |
| 24. FUNERAL DIRECTOR NAME HARDESTY F.H. | | ADDRESS GAMBRIELS | | | | |

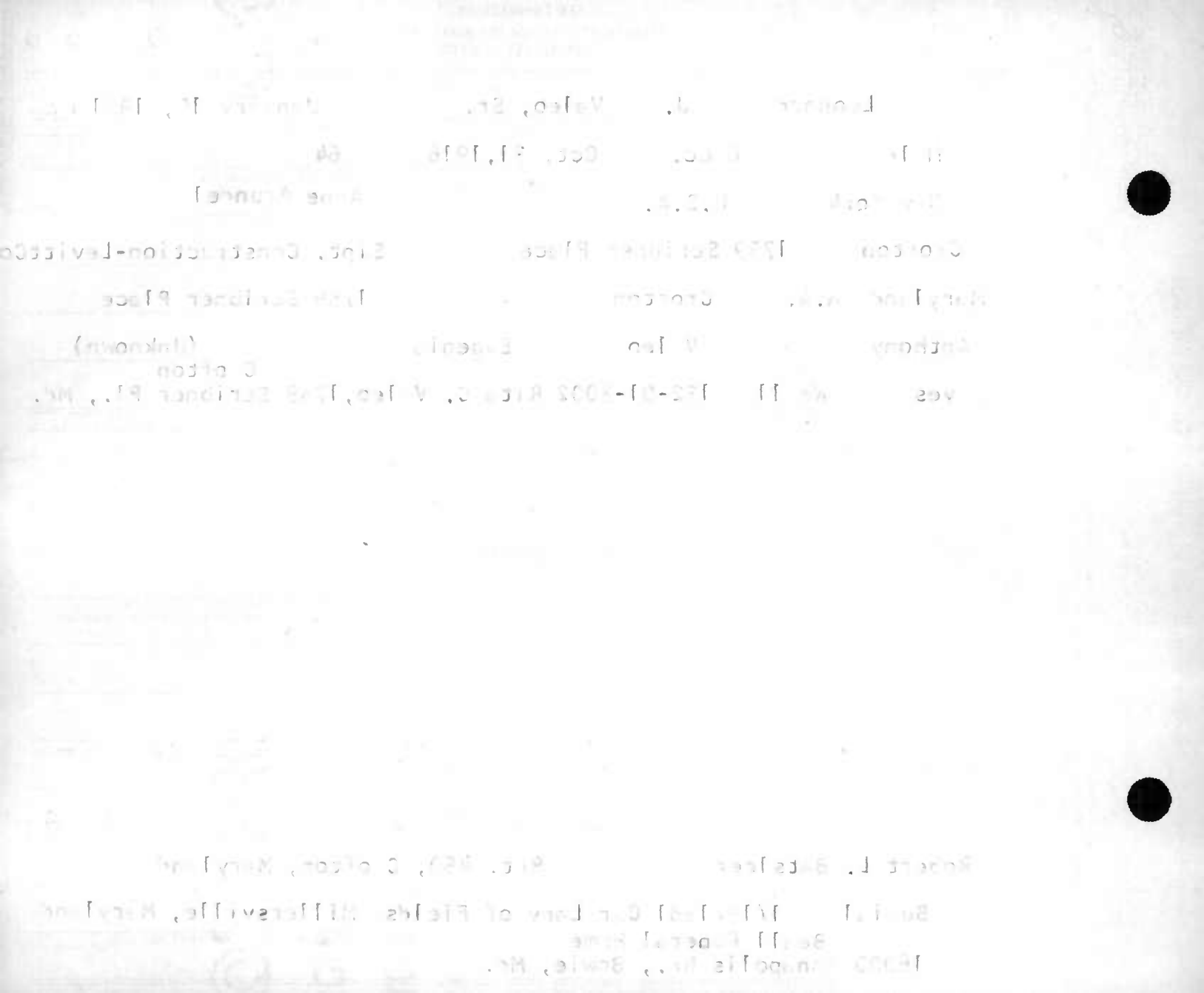
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 1 0 0 2 6 8 | |
|--|--|---|--|---|--|--|--|--|--|---------------|--|
| FOR 1- STATE REGISTRAR | | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Leonard J. Valeo, Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR January 15, 1981 | | | 2b. HOUR 1:00 PM | | | | | |
| 3. SEX Male | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 31, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Crofton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1759 Scribner Place | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supt. Construction-LevittCo | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Crofton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1759 Scribner Place | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Anthony Valeo | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eugenia (Unknown) | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT ADDRESS Rita C. Valeo, 1759 Scribner Pl., Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) anxiety M2. 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) hypertension (c) diabetes | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12/17 19 79 to 1/15 19 81 , that (I) (we) last saw the deceased alive on 1/14 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Robert L. Batsleer | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 1/15/81 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert L. Batsleer | | | 22e. ADDRESS Ret. 450, Crofton, Maryland | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/19/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Our Lady of Fields | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Mttersville, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Beall Fubera | | | ADDRESS 16000 Annapolis Rd., Bowie, Md. | | | 25a. DATE JAN 28 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

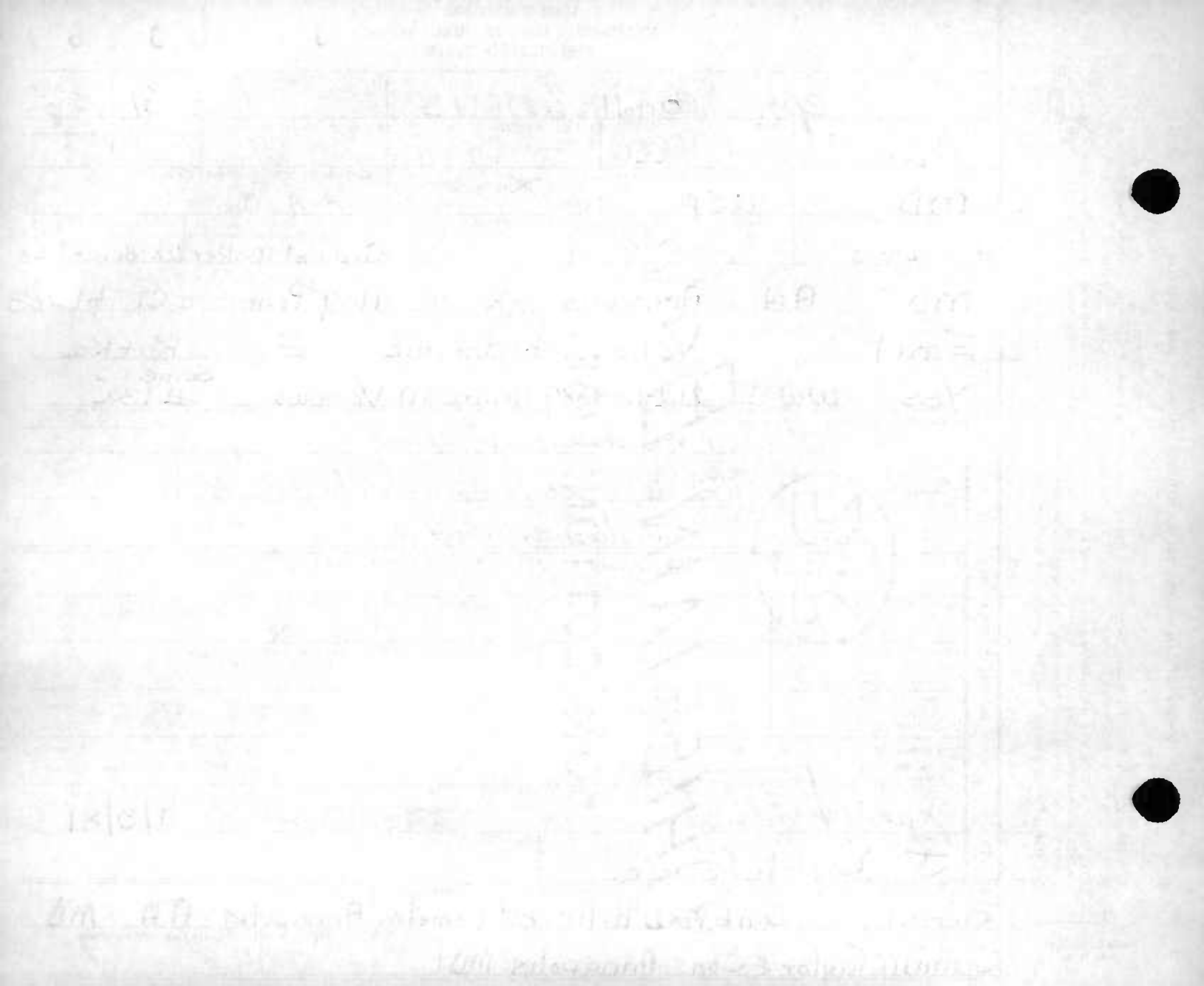
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 81 00269 | |
|--|--|--|--|--|--|---|--------------------------|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Joseph Carroll Vanous | | | | | 2a. DATE OF DEATH MONTH 1 DAY 3 YEAR 81 | | 2b. HOUR 330 P.M. | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH 7 DAY 17 YEAR 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH A.A. Co. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A.A.G.M. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK, FOR MOST OF WORKING LIFE) Cabinet Maker Woodcraft Co. | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD | | 13b. COUNTY AA | | 13c. CITY OR TOWN Annapolis | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1109 Primrose Ct, Apt 203 | | | |
| 14. FATHER'S NAME FIRST Emil MIDDLE LAST Vanous | | | | 15. MOTHER'S MAIDEN NAME FIRST Katherine MIDDLE E LAST Kafka | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. 111-16-8587 | | 17. INFORMANT Anna M. Vanous | | ADDRESS Same as #13a | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 1850 DUE TO, OR AS A CONSEQUENCE OF (b) Prostatic Carcinoma metastases to DUE TO, OR AS A CONSEQUENCE OF (c) the skin, cns and bone | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE J. Lichtenstein | | | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/3/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Lichtenstein | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Jan 6, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemet. | | 23d. LOCATION CITY OR TOWN Annapolis COUNTY AA STATE MD | | | |
| 24. FUNERAL DIRECTOR NAME John M. Taylor & Sons, Annapolis, MD | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the medical examiner's report must be attached to this certificate.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 81 000 270 | |
|---|--|---|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALICE READ WARD | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 1, 1981 | | 2b. HOUR 8:17 AM | |
| 3. SEX FEMALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR August 10, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 85 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE Maryland | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 403 G. Secluded Post Circle | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Eijah Read | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Sheets | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Linthicum, Md 21090 Kathryn Payne, 17 Patapsco Rd. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MI DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Marc Kaplan | | | | DEGREE M.D. | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARC A. KAPLAN, M.D. | | | | 22e. ADDRESS 7845 OAKWOOD ROAD SUITE 200 GLEN BURNIE, MARYLAND 21061 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/5/81 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | | | |
| 24. FUNERAL DIRECTOR 1630 Edmondson Ave., Catonsville, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 2 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |
| Witzke Funeral Home of Catonsville, P.A. 21228 | | | | | | | | | | | |

BP

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1000

| | | | | |
|------|-----|-----|--------------|------|
| NAME | AGE | SEX | RELATIONSHIP | DATE |
| JOHN | 25 | M | SON | 1950 |
| MARY | 22 | F | DAUGHTER | 1951 |
| JOHN | 20 | M | SON | 1952 |
| MARY | 18 | F | DAUGHTER | 1953 |
| JOHN | 15 | M | SON | 1954 |
| MARY | 12 | F | DAUGHTER | 1955 |
| JOHN | 10 | M | SON | 1956 |
| MARY | 8 | F | DAUGHTER | 1957 |
| JOHN | 6 | M | SON | 1958 |
| MARY | 4 | F | DAUGHTER | 1959 |
| JOHN | 2 | M | SON | 1960 |
| MARY | 1 | F | DAUGHTER | 1961 |

MADE AT NEWARK, N.J.
DATE OF MANUFACTURE 1961

MADE AT NEWARK, N.J.

[Handwritten signature]

JAN 5 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8100271 | | | |
|--|--|---|--|---|--|--|--|
| FOR 1. STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMMA GLENDORA WARD | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 4 81 | | 2b. HOUR M | |
| 3. SEX F | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 8 6 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN FACILITY, GIVE STREET ADDRESS) 117 RIVER VIEW AVE. | | 12a. USUAL OCCUPATION (IF OR WORK FOR MOST OF WORKING LIFE) STATE OF MD. | | 12b. KIND OF BUSINESS OR INDUSTRY Ret. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. CITY OR TOWN 13c. STREET ADDRESS MD. AA ANNAPOLIS 117 RIVER VIEW AVE. | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN W BALL | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZA CRUTCHLEY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. — | | 17. INFORMANT ADDRESS 1936 JACKSON AVE MELBOURNE FLA. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/5 19 71, to 1/4 19 81, that (I) (we) lost saw the deceased alive on 12/18 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Rodney L. Beinhart MD | | | | DEGREE ATTENDING PHYSICIAN | | 22c. DATE SIGNED 1/6/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RODNEY L. BEINHART | | | | 22e. ADDRESS Forest Dr. Annapolis, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1/8/81 | | 23c. NAME OF CEMETERY OR CREMATORY Snake Burying | | 23d. LOCATION Galesville AA MD. | |
| 24. FUNERAL DIRECTOR John M. Lyndon | | | | ADDRESS Annapolis, MD. | | 25. DATE REC'D BY REGISTRAR JAN 12 1981 | |
| | | | | 26. REGISTRAR'S SIGNATURE [Signature] | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 1 0 0 2 7 2 E.S.T. | | | |
|---|--|--|--|---|--|--|--|-----------------------|--|--|-----|---------|----------|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| RICHARD | | S. | | WATKINS | | JR. | | JANUARY 4, 1981 | | | | 4:37 A. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Male | | Negro | | 9 28 02 | | 78 | | YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| MD | | USA | | | | ANNE ARUNDEL COUNTY | | | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| MD | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 201 N. Washington St. | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| FIRST | | MIDDLE | | LAST | | FIRST | | MIDDLE | | LAST | | | |
| Richard | | S. | | Watkins | | Hester | | Brown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | St. | |
| No | | 215-05-6245 | | Naricca Watkins | | 201 N. Washington | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute MIOCARDIAL INFARCT</u> <u>1850</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CARCINOMA PROSTATE</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 12/24/80 | | BILATERAL ORCHIDECTOMY | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/24/80</u> , 19____, to <u>1/3/81</u> , 19____, that (I) (we) lost saw the deceased alive on <u>1/3/81</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | | | |
| <u>Victor Salama</u> | | | | | | 1/6/81 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| VICTOR SALAMA, M. D. | | 95 AQUAHART ROAD GLEN BURNIE, MARYLAND 21061 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | |
| Burial | | 1/9/81 | | Md. Nat. Mem. Pk. | | Laurel, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| NAME | | ADDRESS | | | | | | | | | | | |
| Wm C March F/H | | 1101 E. North Ave | | JAN 7 1981 | | | | | | | | | |



270141

DATE OF BIRTH: 12/10/1958 18:10A

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8100273

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) CHARLES FERDINAND WAYSON, SR. | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 23, 1981 | | | 2b. HOUR 5:30 AM | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR JUNE 14, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8059 Green Orchard Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter | |
| 13a. STATE Maryland | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harry Wayson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenny UNKNOWN | | 16. STREET ADDRESS Apartment # 11 8059 Green Orchard Rd. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT (Wife) ADDRESS Mrs. Elizabeth Wayson Same as # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ATHEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) 5 1/2 years | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | | | | | | |
| 19a. DATE OF OPERATION — | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. — 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-22 , 19 84 , to 1-23 , 19 81 , that (I) (we) lost saw the deceased alive on 1-10 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Leon C. Perry | | DEGREE MD. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-23-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leon C. Perry MD. | | 22e. ADDRESS 325 HOSPITAL DRIVE, GLEN BURNIE, MD. 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 26 JAN. 81 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md. | |
| 24. FUNERAL DIRECTOR NAME R. B. Hopkins | | DATE REC'D BY REGISTRAR JAN 27 1981 | | | | | |
| Singleton Funeral Home Maryland | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8100274

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ROSE SOPHIE WHIPPLE | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 9, 1981 | | | 2b. HOUR P 4:15 M | | | | |
| 3. SEX FEMALE | | 4. RACE CAU | | 5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 2, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | | | | |
| 10. CITY OR TOWN OF DEATH FORT MEADE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KIMBROUGH ARMY COMMUNITY HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MARYLAND | | | | | 13b. COUNTY ANNE ARUNDEL | | 13c. CITY OR TOWN GRAMBRILLS | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WEYER | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST 2410 SUNSHINE WAY GRAMBRILLS, MD 21054 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 098-01-9243 | | 17. INFORMANT ADDRESS YVONNE M. KLEIN/DAU 2410 SUNSHINE WAY GRAMBRILLS, MD 21054 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SHOCK, POSSIBLY SEPTIC (c) CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS 48 HRS MANY YEARS | | |
| | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6 JANUARY 19 81, to 9 JANUARY 19 81, that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on 9 JANUARY 19 81, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>Alice M. Mascette</i> MD | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 9 JANUARY 81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALICE M. MASCETTE, M.D. | | | | | 22e. ADDRESS BOX 388, WALTER REED ARMY MEDICAL CENTER WASHINGTON, D.C. 20012 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | | 23b. DATE 1/9/81 | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | | ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 26 1981 | | | |

MEDICAL CERTIFICATION

Inventory

18/01/18
Baito, 18/01/18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

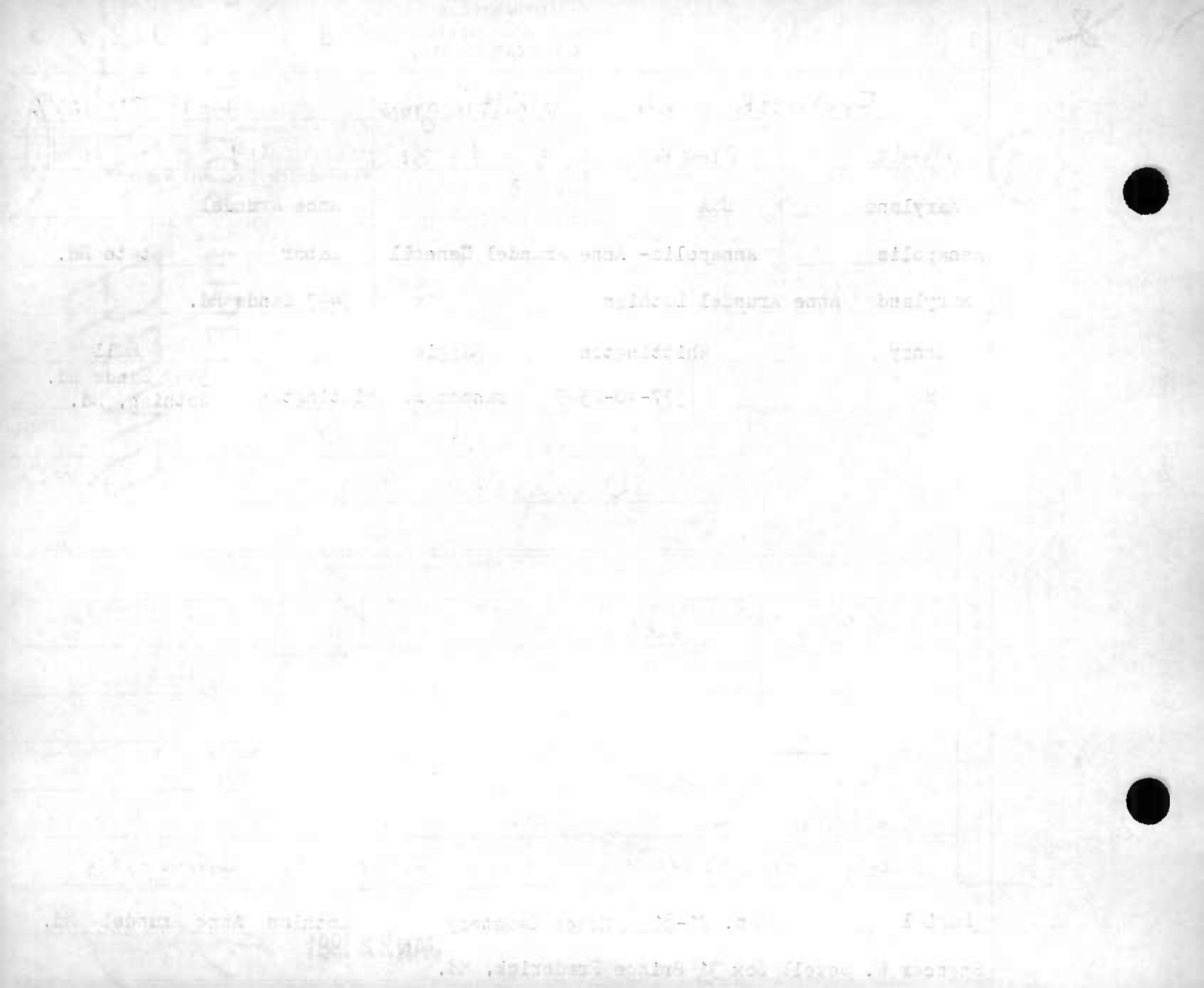
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8100275 | |
|--|--|---|--|---|---|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Frederick W. Whittington | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-18-81 | | | 2b. HOUR 12:19 AM | | | |
| 3. SEX Male | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 5-4-31 | | 6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Annapolis- Anne Arundel General | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor | | 12b. KIND OF BUSINESS OR INDUSTRY State Rd. | | | |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Lothian | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 5497 Sands Rd. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Whittington | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Hall | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 577-40-2569 | | 17. INFORMANT Frances B. Whittington | | ADDRESS 5497 Sands Rd. Lothian, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca esophagus c DUE TO, OR AS A CONSEQUENCE OF (b) bronchial fistula DUE TO, OR AS A CONSEQUENCE OF (c) 1 week Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION 1-5-81 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Same | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1-5 , 19 81 , to 1-18 , 19 81 , that (I) (we) last saw the deceased alive on 1-17 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Karl Holtschuh | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1-18-81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KARL HOLSCHUH | | | | 22e. ADDRESS 104 Forbes St. Annapolis | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 21-81 | | 23c. NAME OF CEMETERY OR CREMATORY Moses Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Lothian Anne Arundel Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Spencer E. Sewell Box 31 Prince Frederick, Md. | | | | | | | | | | | |

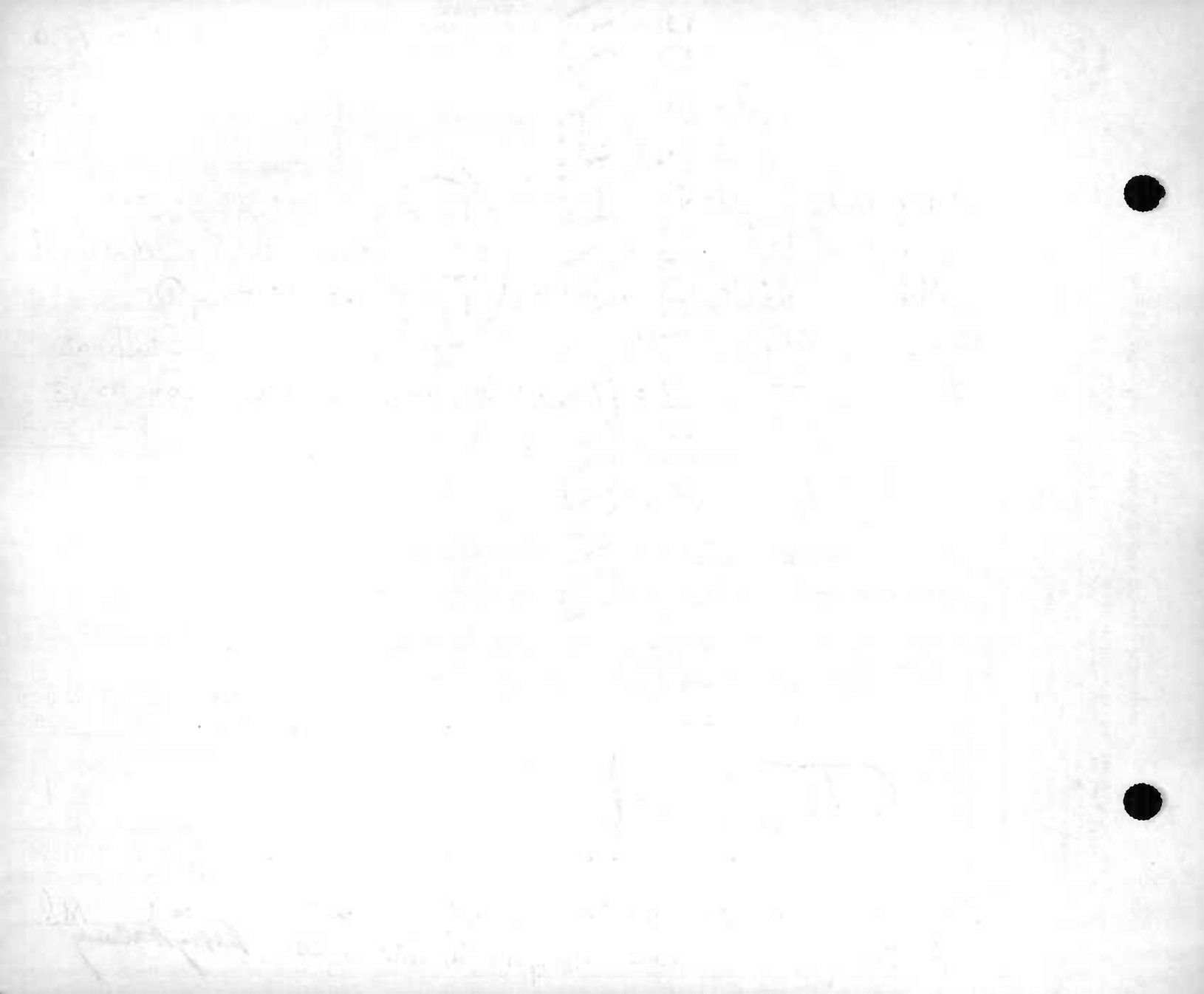
JAN 22 1981

REGISTRAR SIGNATURE



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 81 00276 | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 2b. DATE KNOWN OF DEATH ESTIMATED | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVELYN Olivia WILCZENSKI | | | | | | | | | | MONTH DAY YEAR 1 5 19 81 | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH (MONTH DAY YEAR) 3-15-1937 | | 6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS. | | IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 1 5 1981 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD | | | | | |
| 10. CITY OR TOWN OF DEATH Cape St. Clair | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 965 Mt. Holly Drive | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Household | | | |
| 13a. STATE Md. | | 13b. COUNTY AACo | | 13c. CITY OR TOWN Cape St. Clair | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 965 Mt. Holly Dr. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Oliver Norfolk | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn Stallings | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 218-34-0564 | | 17. INFORMANT William Wilczenski | | ADDRESS Same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun Wound of Chest 9551 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? 1 5 19 81 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self-inflicted | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 965 Mt. Holly Drive, Cape St. Clair/ Anne Arundel County MD | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Thomas D. Smith | | | | TITLE (SPECIFY) M.D. Deputy Chief | | | | DATE SIGNED 1/6/81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS 111 Penn Street, Baltimore, MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | 23b. DATE 1-6-81 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balt Md | | | |
| 24. FUNERAL DIRECTOR NAME Hardesty Funeral Home | | | | ADDRESS Annapolis Md | | 25a. DATE REC'D. BY REGISTRAR JAN 6 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |



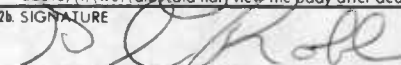

HOSPITAL-ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH-16 25M
(VRA 15.4) 1/79

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained and held within 72 hours after death by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1- FOR STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | 81 00277 | | REG. NO. | | EDT | |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDNA L. WILLEY | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 5, 1981 | | | | 2b. HOUR 8:35A M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 2, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | | | 13b. COUNTY A.A. Co. | | 13c. CITY OR TOWN Pasadena | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William James | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Ryer | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 216 32 0223 | | 17. INFORMANT ADDRESS Viola C. Willey 2003 Park Dr. Pasadena Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of LARYNX</u> 1619 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/17</u> , 19 <u>80</u> , to <u>1/5</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>1/4</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE  | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENN F. ROBBINS, M.D. | | | | 22e. ADDRESS 1404 CRAIN HIGHWAY, #300 GLEN BURNIE, MARYLAND 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/8/81 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Pk | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md. | | | |
| 24. FUNERAL DIRECTOR NAME George J. Gonce | | | | ADDRESS 4001 Ritchie Hgwy. Balto 21225 | | 25a. DATE REC'D. BY REGISTRAR JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE  | |

• 454

1893-1894

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 74 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
15M 7/76

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 00278 | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1- STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) EVELYN C. WOOD | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 1-14-81 | |
| 3. SEX F 4. RACE W 5. DATE OF BIRTH 6 10 02 6. AGE (IN YEARS) 78 7. IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> 8. IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | | | | | | | | | | 2b. HOUR M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Annapolis, Maryland 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 2c. DATE PRONOUNCED DEAD 1-14-81 2d. HOUR M | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter | |
| 12b. KIND OF BUSINESS OR INDUSTRY Self Emp. | | | | | | | | | | | |
| 13a. STATE Md. 13b. COUNTY A.A. Co. 13c. CITY OR TOWN Annapolis 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 729 Rosedale | | | | | | | | | | | |
| 14. FATHER'S NAME John W. Wood 15. MOTHER'S MAIDEN NAME Celestina L. Arth | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 212-12-2489 17. INFORMANT William J. Boehm ADDRESS 124 South St Ann. Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Golden | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION _____ 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____ 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH _____ 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) _____ | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) _____ 21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____ | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Charles H. Hardesty M.D. Deputy TITLE (SPECIFY) _____ MEDICAL EXAMINER DATE SIGNED 1-14-81 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Charles H. Hardesty ADDRESS Annapolis, Md | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation 23b. DATE 1-15-80 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory 23d. LOCATION CITY OR TOWN Washington D.C. COUNTY _____ STATE _____ | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME T.A. Hardesty ADDRESS Annapolis, Maryland 21401 25a. DATE REC'D. BY REGISTRAR JAN 20 1981 25b. REGISTRAR'S SIGNATURE Anthony J. Brady | | | | | | | | | | | |

1-14-24

Handwritten notes

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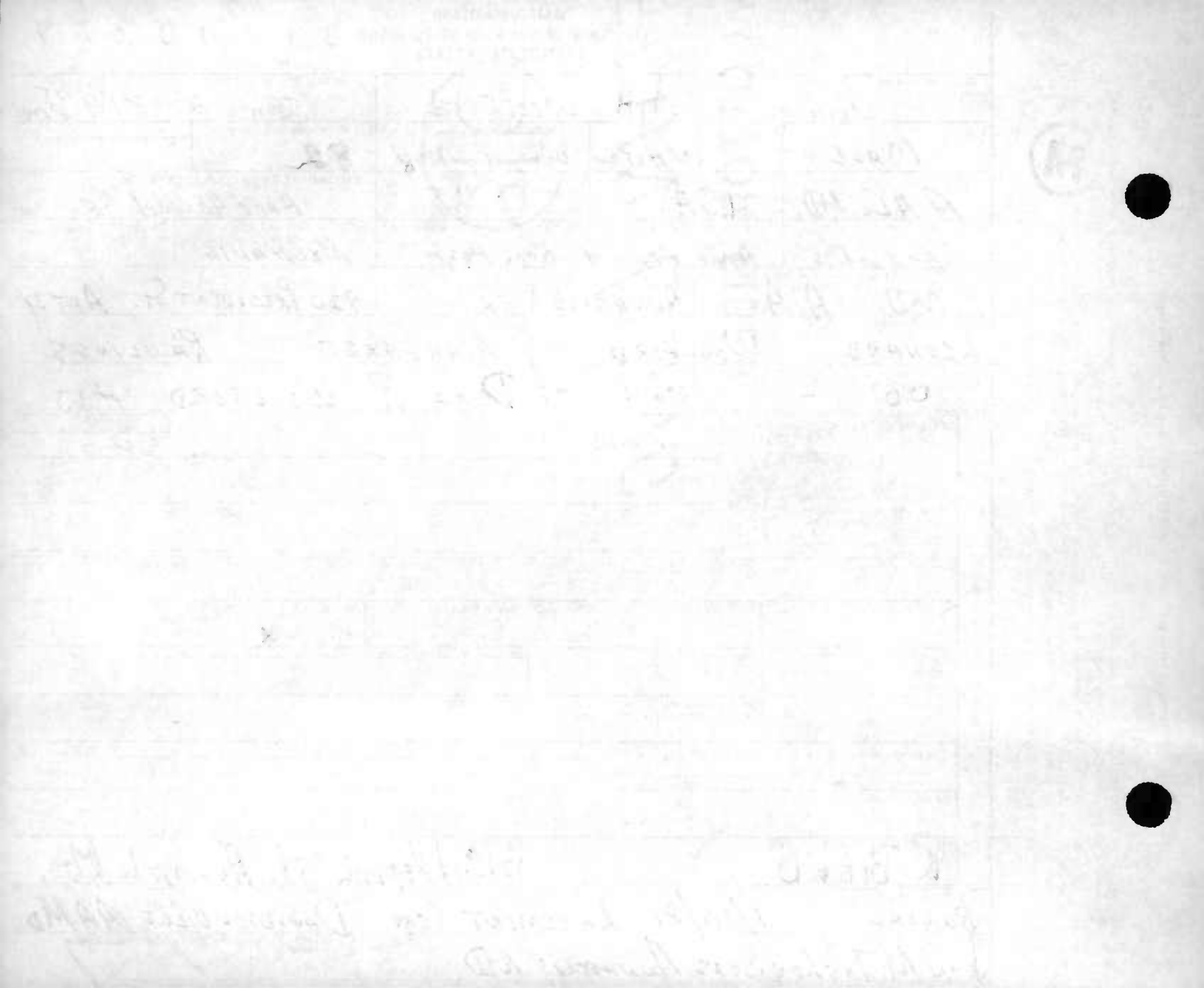
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 1 | 0 | 0 | 2 | 7 | 9 |
|--|--|--|---|--|---|--|--|---|---|--|--------------------------------|-----------------------------------|--------------------------------|--------------------------------|---|---|
| 1 - FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Joseph Woolford | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR Jan 27 81 | | | | 2b. HOUR 9 ⁴⁵ PM | | |
| 3 SEX MALE | | | 4 RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR Oct 11 1898 | | | 6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) A.A.G. MD. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp. | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANIC | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE MD | | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN ANNAPOLIS | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 910 PRESIDENT ST. APT 4 | | | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST LEONARD WOOLFORD | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET RAWLINGS | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 212-16-3347 | | | 17. INFORMANT ADDRESS DORA R WOOLFORD #13 | | | | | | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COPD 4960 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/27/81 to 1/29/81, that (I) (we) last saw the deceased alive on 1/27/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE A. Breen | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/29 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. BIERD | | | | 22e. ADDRESS 121 CALLEDAL ST. ANNAPOLIS MD. | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 1/30/81 | | 23c. NAME OF CEMETERY OR CREMATORY LAKEMONT CEM. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE DAVIDSONVILLE AAMD | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS JOHN M. TAYLOR SONS ANNAPOLIS MD. | | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 1 0 0 2 8 0 | |
|--|--|---|--|---|--|---|--|---|--|--|--|
| FOR 1. STATE REGISTRAR | | REG. NO. | | | | | | | | E.S.T. | |
| 1. DECEASED NAME (TYPE OR PRINT) CARLENA A. WOODS | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 29, 1981 | | | | 2b. HOUR 7:29A M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 16, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 | | IF UNDER 1 YEAR MONTHS DAYS YRS. | | IF UNDER 24 HRS HOURS MIN. MD. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY | | | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Lady | | 12b. KIND OF BUSINESS OR INDUSTRY Kann's Dept. Store | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C. | | | | | | 13b. CITY OR TOWN Washington | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 1341 Vista Street N.E. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles B. Perry | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Biret | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 578-12-3989 | | 17. INFORMANT James A. Whitefield | | ADDRESS 1341 Farrara Drive | | Odenton, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4275 Cardiac arrest IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) 4275 Conditions, if any, which give rise to immediate cause (a), stating the underlying cause lost. (c) 4275 DUE TO, OR AS A CONSEQUENCE OF (c) 4275 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-20 , 19 81 , to 1-29 , 19 81 , that (I) (we) lost saw the deceased alive on 1-24-81 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE M. A. Kaplan | | | | | | DEGREE M.D. | | 22c. DATE SIGNED Jan. 29, 1981 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARC A. KAPLAN, M.D. | | | | 22e. ADDRESS 7845 OAKWOOD ROAD SUITE 200 GLEN BURNIE, MARYLAND 21061 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2-2-81 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington - D.C. | | | | | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons F.H. P.A. Hyattsville, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 5 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

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Charles

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 81 00281 | |
|--|--|--|--|---|--|--|--|--|---------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Paul Duffield Wright | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-21-81 | | | 2b. HOUR 4:40 PM | | |
| 3. SEX M | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 9 15 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HAGEN Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY MARINE | | | |
| 13a. STATE MD. | | | | | | 13b. COUNTY AA | | 13c. CITY OR TOWN Annapolis | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Paul D. Wright | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Oliver Pauline | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 192-05-3220 | | 17. INFORMANT ADDRESS Chynette W. Wright #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema. 4349 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Hypertension | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes Mellitus | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 1/19/81 to 1/21/81, that (1) we last saw him/her on 1/21/81, and that in my/our opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) | | | | | | | | | | | |
| 22b. SIGNATURE George C. Samaras | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/21/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) George C. Samaras | | | | | | 22e. ADDRESS 1616 Forest Drive | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Cremation | | 23b. DATE 1/22/81 | | 23c. NAME OF CEMETERY OR CREMATORY F. Lincoln | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood PG. MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME John M. Taylor & Sons | | | | ADDRESS Anne Arundel, MD | | 25a. DATE REC'D. BY REGISTRAR JAN 23 1981 | | 25b. REGISTRAR'S SIGNATURE History/Rebony | | | |

George C. Johnson
Hypertension

Diastolic pressure

George C. Johnson
Hypertension

TO HOSPITAL-ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

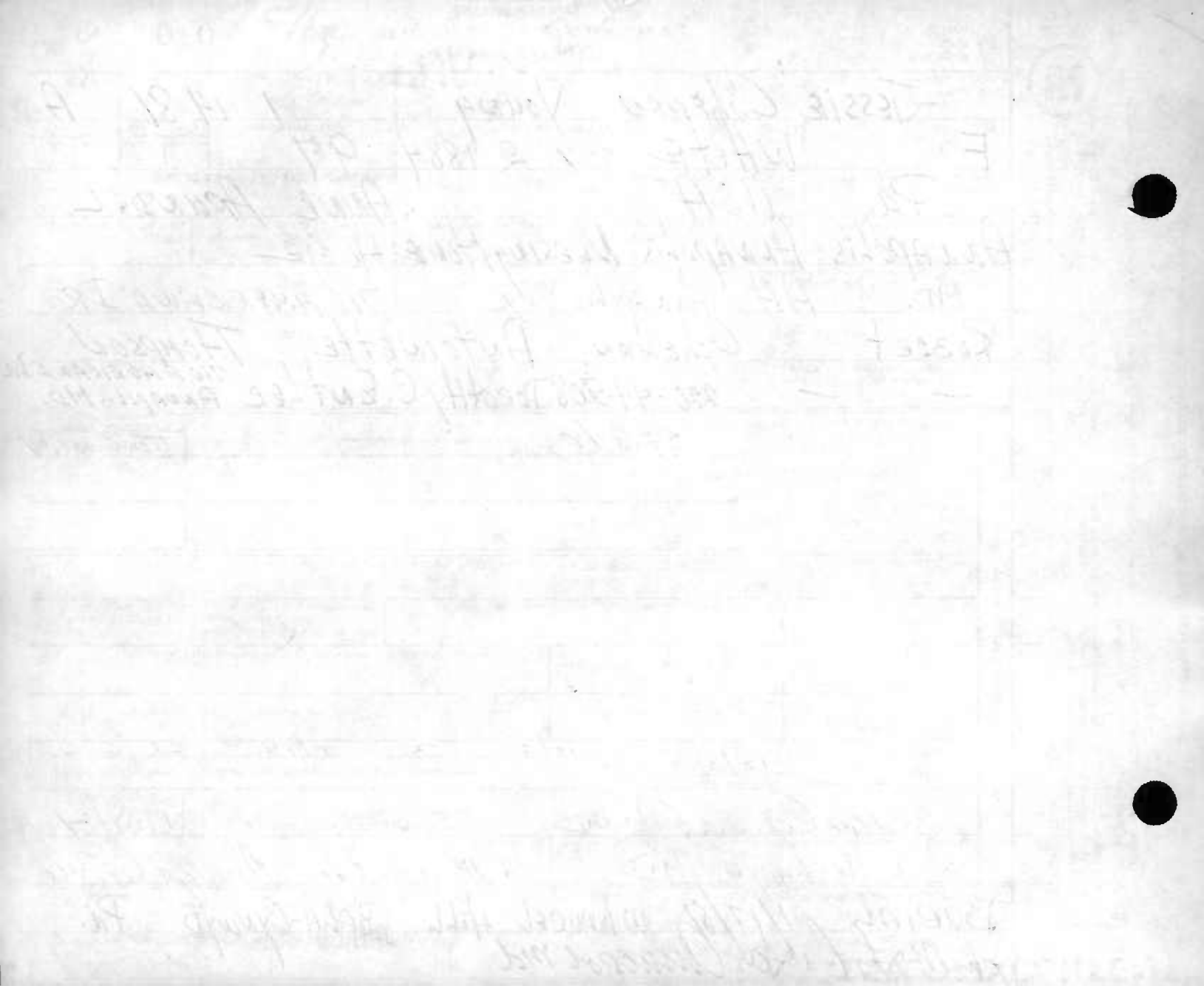
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 1 0 0 2 8 2
REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JESSIE COHENMAN YOUNG | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 14 81 | | 2b. HOUR A | |
| 3. SEX F | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 1 2 1884 | | 6. AGE (IN YEARS LAST BIRTHDAY) 97 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH ANNAPOHIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNAPOHIS NURSING HOME | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD. | | 13b. COUNTY AA | | 13c. CITY OR TOWN ANNAPOHIS | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS 710 AMERICANA DR. | | 14. FATHER'S NAME FIRST MIDDLE LAST ROBERT COHENMAN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANTOINETTE THOMPSON | | 16. SOCIAL SECURITY NO. 220-445008 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) — | | 16b. SOCIAL SECURITY NO. 220-445008 | | 17. INFORMANT DOROTHY C. ENTLER | | ADDRESS 710 AMERICANA DR. ANNAPOHIS MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/27 , 19 73 , to 1/14 , 19 81 , that (I) (we) last saw the deceased alive on 12/31 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE R. I. Hochman, MD | | | | DEGREE | | 22c. DATE SIGNED 1/14/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. I. Hochman, MD | | | | 22e. ADDRESS 16 Murray Ave, Annapolis, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL | | 23b. DATE 1/17/81 | | 23c. NAME OF CEMETERY OR CREMATORY W. LAUREL HILL | | 23d. LOCATION CITY OR TOWN COUNTY STATE BAND-CYMD Pa. | |
| 24. FUNERAL DIRECTOR NAME John M. Lutz ADDRESS Annapolis MD. | | | | 25. DATE OF DEATH REGISTERED 1/17/81 | | | |

BP



Items 19b, 21a-22a G553 3/10/81

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 7100283

FOR dad
1- STATE REGISTRAR

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
FRANCIS J. ZEILER

2a. DATE OF DEATH MONTH DAY YEAR
1/23/81

2b. HOUR
320 P.

3 SEX
Male

4 RACE
White

5. DATE OF BIRTH MONTH DAY YEAR
2/4/24

6 AGE (IN YEARS LAST BIRTHDAY)
56

IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland

7b. CITIZEN OF WHAT COUNTRY?
United States

8 MARRIED ☐ NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD.

10 CITY OR TOWN OF DEATH
Odenton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Crownsville hosp center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Elevator-Operator

12b. KIND OF BUSINESS OR INDUSTRY
City

13a. STATE
Maryland

13b. COUNTY
- -

13c. CITY OR TOWN
Baltimore

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS
226 S. Wolfe St.

14 FATHER'S NAME FIRST MIDDLE LAST
Frank G. Zeiler

15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Anna - Kister

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO

16b. SOCIAL SECURITY NO.
220-14-6692

17. INFORMANT ADDRESS
Stephen Zeiler 956 Fairmont Ave.

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4850 IMMEDIATE CAUSE (a) Bronchopneumonia

DUE TO, OR AS A CONSEQUENCE OF (b) _____

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____

DUE TO, OR AS A CONSEQUENCE OF (c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 wks

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
cirrhosis of the liver / fracture of hip

19a. DATE OF OPERATION
12/11/80

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Femur fracture left hip

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
PM P.M. 12/10/80 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
fell down

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
hospital

21f. LOCATION STREET CITY OR TOWN COUNTY STATE
Crownsville, Md. 21032

22a. I certify that (I) (this hospital) attended the deceased from **June** 19**79** to **1/23/81** 19**81**, that (I) (we) last saw the deceased alive on **1/23/81** 19**81** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. **Natural**

22b. SIGNATURE
A. Orer MD.

DEGREE
MD.

22c. DATE SIGNED
1/23/81

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. ORER

22e. ADDRESS
Crownsville hosp. center

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

23b. DATE
Jan. 26, 1981

23c. NAME OF CEMETERY OR CREMATORY
OakLawn Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE
- - Baltimore Co., Md.

24. FUNERAL DIRECTOR NAME ADDRESS
Lilly & Zeiler Inc. F.H. 1901 Eastern Ave.

25a. DATE REC'D. BY REGISTRAR
JAN 27 1981

25b. REGISTRAR'S SIGNATURE
Ruby McHenry



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